HOSPITAL ABSTRACTS

A MONTHLY SURVEY OF WORLD LITERATURE
PREPARED BY THE DEPARTMENT OF HEALTH
AND SOCIAL SECURITY

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HOSPITAL ABSTRACTS

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HOSPITALS IN GREAT BRITAIN

1065. MacQueen, L. and Kerr, A. B. **The Western Infirmary 1874-1974: a century of service to Glasgow.** Glasgow, John Horn, 1974, viii, 219pp. £3.00

This is a history of the development of the Western Infirmary, Glasgow, from the admittance of the first patient in 1874 to the completion of the first phase of the rebuilding of the Infirmary in 1974. The role of the hospital, its staff and early developments are described, including the development of individual medical and surgical specialties, radiology and radiotherapy departments, and laboratory services. The proposed rebuilding of the Infirmary and demolition of the nineteenth century blocks are considered.

1066. Houlder, C. A. **Closure of a hospital and some people with epilepsy.** *British Medical Journal*, London, 1977, May 14, vol. i, pp. 1266-1267.

St. Faith's Hospital, Brentwood, treats epileptic patients exclusively. Altogether about 3000 people live in the hospital and in the epileptic colonies; they tend to be underprivileged and unable to represent their own interests effectively. A typical patient who finds his or her way into an epileptic colony or St. Faith's Hospital is not considered acceptable for a bed in a psychiatric or subnormal hospital. Such patients require special medical and nursing care. To fill the needs of this special group of patients seven epileptic colonies in England and Wales, and two special hospitals, St. David's and St. Faith's, were established between 1910 and 1920. The effect of the Reid report, 'People with epilepsy' published in 1969 is discussed, and the recommendations outlined. The current state of St. Faith's Hospital is described, and it appears likely that it will soon be closed. It is recommended that the hospital should be considered in a supra-regional context, and developed to become an important unit for epileptics in South-east England.

HOSPITALS IN OTHER COUNTRIES

See also Abstract Nos. 1074, 1202

1067. Izzo, G. Alcuni nodi della tutela sanitaria in Italia. **[Some problems of health care in Italy.]** *Problemi della Sicurezza Sociale*, Roma, 1976, July/Aug., vol. 31, no. 4, pp. 353-368.

In 1973 expenditure on health accounted for nine per cent of gross national product in Italy and social security contributions amounted to 19.4 per cent of net internal income. The author discusses these figures within the wider context of the current policy for the redistribution of income in Italy. He also examines the problem of financing the health service and the containment of health expenditure. Prescription charges may

have to be imposed to curb excessive expenditure on pharmaceutical products. Alternatively some drugs could be provided free of charge and others of lesser or little therapeutic value could be paid for by the patient. Furthermore the prices charged by drug companies warrant investigation. Another problem is the increasing proportion of old people in the Italian population, and domiciliary services must be provided for them to release hospital beds for acute cases. Finally, measures to reduce industrial pollution could have a beneficial effect on health expenditure by reducing the incidence of chronic respiratory disease.

1068. GREAT BRITAIN. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. **Health buildings in hot climates: design guide for thermal performance by YRM International.** London, DHSS, 1976, [84]pp. £10.00

This Design Guide is intended to facilitate the design and evaluation of health buildings in hot climates, with particular regard to the way in which building design can affect the interior environment. It is primarily concerned with the thermal performance of buildings in hot climates, but reference is also made to the other aspects of environmental design. The guide is in three main sections. The first describes the classification of climates adopted for the Guide and their characteristics, and it includes a brief description of the comfort limits for these climates. The second section is concerned with thermal performance criteria for form and fabric of buildings and suggests specifications which will meet these criteria. The third section deals with thermophysical properties of materials, and includes a bibliography and a source of further information.

1069. NANNEY, L. K. and BATTEN, G. R. **Urban medical center serves regional rural population.** *Hospitals*, Chicago, 1977, Feb. 16, vol. 51, no. 4, pp. 61-63.

The 349-bed Mid-Maine Medical Center, Waterville, was formed by the amalgamation of two independent, not-for-profit community hospitals which already had sharing arrangements and had been recognized as providing regional medical care. The population served by the centre is predominantly rural. This fact is the basis of the philosophy—to provide an integrated system of primary health care for the population in the centre's primary and secondary service areas, with major emphasis on the rural areas where health care is non-existent or inadequate. Some examples of the way in which this is done include: dental care for children of low-income families; administrative support and other services for a 16-bed hospital; laboratory and consultative services for a 36-bed hospital; paediatric clinic programme. These and other arrangements are the result of requests to the medical center from individual communities and institutions.

PLANNING, DESIGN AND CONSTRUCTION

1070. Services techniques et service du plan: actions et interactions dans le cadre de la réglementation nouvelle. **[Technical services and the planning department: action and interaction in the framework of the new regulations.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1977, April, vol. 32, no. 379, pp. 49-56.

In the light of recent French legislation concerning the execution of major hospital construction works the authors discuss the changing role of the technical department.

As well as carrying out its traditional task of day-to-day maintenance, this department could be closely involved in new construction work. The authors sketch out the various ways in which this could be achieved. They then describe the functions of the planning department, which include the planning of new investment programmes, and the preparation of detailed technical programmes. They envisage close co-operation between the technical and planning departments in the future in the preparation and execution of construction projects.

DETERMINING SIZE OF HOSPITAL AND BED NEEDS

See Abstract No. 1078

BUILDING COSTS

1071. SJUKVÅRDENS OCH SOCIALVÅRDENS PLANERINGS- OCH RATIONALISERINGSINSTITUT. Modell för redovisning av byggnadskostnader för olika arbetsområden inom sjukvårdsbyggnader. **[Model for reporting building costs for different work areas within medical care buildings.]** (Spri rapport 7/76) Stockholm, Spri, 1977, 23pp.

This report describes a method for allocating building costs to work areas and for obtaining corresponding building cost statistics. The statistics on building costs which have been obtained using the statistical model can be reported both as complete building costs for different building parts (e.g. ventilation) and in the form of differentiated building costs for different departments in medical care buildings. There is also the possibility of calculating relative costs for different departments or department groups.

CONSTRUCTION METHODS AND BUILDING MATERIALS

See Abstract No. 1068

HOSPITAL DESIGN

See also Abstract No. 1068, 1074

1072. **Diverse projects provide special functions, coordinate with hospital-community character.** *Hospitals*, Chicago, 1977, March 16, vol. 51, no. 6, pp. 46, 48, 50-51.

Lake Forest (Ill.) Hospital has been actively expanding and developing its facilities for the last 10 years. Among the projects completed are: an expanded underground diagnostic and radiotherapy department; a new physical therapy department including hydrotherapy areas; new housing for nurses and technical staff; a continuing education and conference centre used for in-service training; an 82-bed long-stay care facility and a new central services block. The new service building can carry out all the needs of the existing buildings on the hospital campus, and houses the boilers, diesel generation, steam to water converters, water chillers, a surgical vacuum system and a compressed air system. The building is of steel frame, masonry and reinforced concrete; and much

of it is surrounded by earth berms which provide control and a gently rolling landscaped appearance. The aims of a comprehensive and sophisticated service have been successfully solved in the long-term planning process and implemented in the design, construction and renovation of the hospital.

1073. SWETCHINE, J. and others. Un exemple de l'hôpital type Duquesne. **[An example of a standard Duquesne hospital.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1977, March, vol. 32, no. 378, pp. 69-80.

Ten Beaune-type hospitals have now been completed and the objectives of speed of construction and savings in costs have been achieved. Because of developments in medical techniques, the need to conserve energy, new fire regulations, the increase in the demand for out-patient services, etc., the French Ministry of Health has invited four firms to submit designs for a new hospital—the Duquesne. There will be two versions—a large 330 to 400-bed model, and a smaller 250-bed. The Duquesne will have one more operating theatre than the Beaune and the pharmacies, laboratories, and sterilisation centres will be larger. A short commentary on the design and lay-out of the new type of hospital is accompanied by 12 informative diagrams and plans.

DESIGN OF INDIVIDUAL GENERAL HOSPITALS

See also Abstract No. 1076

1074. OLSEN, V., SKAUTRUP, H. and CLAUSEN, S. Frederiksborg amts sygehus i Helsingør. **[The Frederiksborg County Hospital, Helsingør.]** *Tidsskrift for danske Sygehuse*, København, 1977, March, vol. 53, no. 3, pp. 37-44.

The 182-bed Frederiksborg County Hospital (Architects: I/S Salling-Mortensen's Tegnestue, Aarhus) was opened on June 1, 1976. There is a three-wing, six-storey ward block, capable of extension in two stages to 360 beds and 700 beds respectively, connected to a three-storey therapy block. There are 91 surgical beds, 81 medical beds, and ten intensive care beds. The department of surgery comprises the children's department and maternity unit, and in addition there are an X-ray department, laboratories, physiotherapy department and a department of anaesthetics. The floor area is 33,530 m^2, comprising a 3,350 m^2 covered car park, the 9,200 m^2 ward block, 6,000 m^2 therapeutic departments, and 3,500 m^2 service area. There are two entrance ways: one for visitors and patients, and one for ambulances, internal traffic and supplies. Internal movements are divided between: basement: supplies and staff; ground floor: public; and first floor: internal patient traffic. The basement houses lockers, workshops, the central supply unit and stores. The ground floor comprises entrance hall, reception, shops, library, and physiotherapy department with an open-air exercise courtyard. Two medical and two surgical floors occupy four storeys of the tower block, each wing containing an identical 18-bed ward; and the kitchens are very successfully installed on the sixth storey. The article is illustrated with three exterior and 11 interior photographs, a ground plan and an exploded diagram of the building.

1075. PLAZA, J. and BALCELLS, S. Le nouvel hôpital de Saint-Jean-de Dieu à Barcelone. **[The new Saint-Jean-de-Dieu hospital, Barcelona.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1977, March, vol. 32, no. 378, pp. 81-85.

The new children's hospital in Barcelona was designed for the Order of St. John of

God by D. Santiago Balcells Gorina. It has 300 beds for children and a separate 40-bed maternity unit. Of conventional design, it comprises an 11-storey block of which the upper six storeys house the children's wards, a three-storey out-patient block with facilities for up to 500 consultations a day, a seven-storey maternity block, and a seven-storey residence for the Brothers of the Order. There are 78 intensive-care beds. The sterilization, laundry, records, and pharmacy services are centralized, and the total area of the hospital is 21,697 m².

EXTENSIONS AND RECONSTRUCTIONS

1076. **Renovation project ensures interim and ultimate operating efficiency.** *Hospitals*, Chicago, 1977, Feb. 16, vol. 51, no. 4, pp. 30, 32.

In 1973, Shadyside Hospital, Pittsburgh, opened a new main complex comprising a three-storey ancillary and support unit and a five-storey, 200-bed nursing tower. But more than half of its 450 beds remained in the old buildings, which lacked air-conditioning and had substandard and fragmented nurses' stations, and patients' rooms which were too small and lacked private toilets. As demolishing and redesigning the interior structural elements was precluded, it was decided to construct tower appendages to the exterior of the building containing toilets and services. One tower was constructed for each pair of patient's rooms. Following construction of the towers the interior was remodelled floor by floor starting at the top. Brief details are given of the new interior finishes and furnishings. Plans of a typical ward floor before and after renovation are included.

WARDS AND PATIENTS' ROOMS

1077. GRAHAM, J. L. **Up-grading of in-patient accommodation at Stobhill General Hospital, Glasgow.** *Hospital and Health Services Review*, London, 1977, May, vol. 73, no. 5, pp. 151-154.

The principles of progressive patient care and grouping as applied to the up-grading of in-patient accommodation are considered. The alterations to the original ward layout of two two-storey wards at Stobhill General Hospital, Glasgow, are discussed. Three main zones with a switch or swing situation between each have been created. The patients' requirements have been largely met, and all rooms have a partially glazed wall which can be screened by the use of a curtain. The nursing services have been centralized accepting the longer distances from the self care areas. The grouping has allowed some sharing of support systems and the switching of staff in an emergency. The benefits of the reorganisation will be the convenience and continuity of care avoiding the transfer of patients to another hospital, and it will also allow the best deployment of trained staff with the use of auxiliary or housekeeping staff in the self-care zone. The major up-grading of two two-storey ward blocks confirms the possibility of incorporating modern ideas into older buildings. Diagrams of the reconstruction are included.

1078. WEEKS, J. and others. **Distribution of room size in hospitals.** *Health Services Research*, Chicago, 1976, vol. 11, no. 3, pp. 227-240.

In the design of such complex buildings as hospitals the planners' problem is to provide a minimal amount of permanent structure so that it shall not get in the way of

the functional behaviour of the occupants and their ability to change their environment. The purposes of this study, which is based on six British teaching hospitals, were: (i) to examine the differences between individual room-size distributions to see if the same or similar room sizes recurred across different hospitals; and (ii) to quantify the approximate increase in floor area that would result if a hospital's unique room-size distribution was generalized so as to be compatible with a limited set of modular room-size dimensions. The evidence seemed to support the view that patterns of work depend more on the ways rooms are used and probably on the services that are available in them than on their sizes. In the hospitals studied, the fact that four room sizes (50, 100, 150 and 200 square feet) appear in the first five in the frequency ranking in four out of six hospitals must be significant. The argument that a hospital 'chassis' needs to allow infinite flexibility in the planning of rooms and circulation areas does not seem to be supported.

ENGINEERING SERVICES

COMMUNICATION SYSTEMS

1079. CONDON, T. B. and KORN, J. T. **Patient support line provides instant response or aid.** *Hospitals*, Chicago, 1977, March 16, vol. 51, no. 6, pp. 93-94, 98, 100.

A patient support line (PSL) system has been developed at Yale-New Haven (Conn.) Hospital to give patients immediate access to help and provide hospital administration with realistic feedback about patient's concerns and medical and non-medical problems. The hospital has developed several systems to help the patient adjust to the different experiences, rules and regulations in the hospital. The PSL is administered by the department of unit management. The original aim of the PSL was to provide an additional communications resource for the patients. The volume of requests recorded since the line was established indicates that this purpose has been fulfilled in a consistent and satisfactory manner. The data collected indicate that the PSL system keeps administration abreast of problem trends, identifies areas of concern and stimulates corrective action.

TRANSPORT IN GENERAL

1080. ANJUERE, G. L'automatisation progressive des transports d'approvisionnement dans les établissements hospitaliers. **[The gradual/phased mechanisation of the transport of supplies in hospitals.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1977, March, vol. 32, no. 378, pp. 64-68.

A scheme for the gradual introduction of automated transport of materials within a 450-bed hospital is described. It is based on the use of the battery-operated Otis Servo-lift which can propel trolleys along automated circuits from the kitchens and central stores to the goods lift and from the lift to other departments on the floors above. Six diagrams explain how the system works.

HEATING

See Abstract No. 1126

VENTILATION AND AIR-CONDITIONING

See Abstract No. 1160

INSULATION AGAINST SOUND AND TEMPERATURE

See Abstract No. 1167

MAINTENANCE OF BUILDINGS AND EQUIPMENT

See also Abstract No. 1070

1081. CLÉMENT, J.-M. La dévolution des travaux d'entretien et de rénovation dans les établissements publics de soins. **[Maintenance and renovation in hospitals.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1977, March, vol. 32, no. 378, pp. 49-52; summaries in English, German, Italian and Spanish, p. 53.

An explanation is given of the French regulations governing the delegation of hospital repairs and renovations to outside contractors. When the repairs are to cost less than 100,000 francs, the work can be assigned by annual contract, by mutual agreement, by tender, or by contract which specifies the maximum and minimum amount of work which may be commissioned over a certain period. For major repairs and reconstructions a direct agreement can be drawn up with the prime contractor, who must be an architect, engineer, or other professionally qualified person. The work is then put out to tender.

PIPING INSTALLATIONS

See Abstract No. 1156

EQUIPMENT, FITTINGS, FURNITURE

INTERIOR DECORATION

1082. WIEKART, K. Van wanden, vloeren en plafonds . . .: enorme keuzemogelijkheid maakt nauwkeurig budgetteren tot een moeilijk karwei. **[Budgeting (for new building projects) is made difficult by the wide range of materials now available for walls, floors and ceilings.]** *Instelling-Management*, Amsterdam, 1977, March, vol. 90, no. 3, pp. 21-24.

Of the total cost of hospital furnishings approximately half is spent on furniture, over a quarter on floor coverings and the remainder on walls and curtains. Modern demands and wide choice of materials make accurate budgeting increasingly difficult. Neither is the distinction between 'construction' and 'furnishings' always clear, as is the case with false ceilings, ceiling plates or double walls concealing pipes and wirings, non-supporting or mobile walls, and some forms of heated flooring. Selection must take account of temperature and air regulation, insulation, hygiene, wear and tear, maintenance and quality. Floor coverings to be chosen vary from soft, semi-soft to hard according to the area (wards, corridors, kitchens, laboratories), and there is a wide selection from linoleum, PVC, tiles and carpeting, with account to be taken of aesthetics, accoustics and cleaning. For walls, windows and ceilings the choice is often determined by

appearance, insulating qualities, fire-resistance, strength and flexibility. TNO-reports (Institute of Technical and Scientific Research) are most valuable on thermic qualities (loss of heat, etc.) and essential on fire-resistance qualities, effects of fumes and high temperatures. The paper includes 10 pictures.

FLOORS AND FLOOR COVERINGS

See Abstract No. 1082

MEDICAL EQUIPMENT

1083. KIRKPATRICK, M. and STANLEY, S. M. **Evaluation of a new single-use thermometer.** *Occupational Health Nursing*, New York, 1976, Dec., vol. 24, no. 12, pp. 9-18.

A total of 1551 single-use thermometers (1028 Fahrenheit and 523 Centigrade) were evaluated by comparative readings with conventional glass/mercury thermometers. The test subjects were patients seen in the medical department of an American company over a 17-month period. A total of three test series of readings were recorded and the results are shown in five tables. Given that the staff were adequately instructed in the administration of the single-use thermometer, it was found to be both more accurate and more consistent than the glass/mercury type. It recorded a temperature in 30 to 60 seconds as opposed to three to five minutes for the conventional type, and was, therefore, less likely to become displaced or even damaged in the patient's mouth. The elimination of the risk of infection or of the thermometer breaking in the mouth, made the single-use thermometer more acceptable to both patients and staff.

STAFF GENERALLY

See also Abstract No. 1157

STAFF COMPLEMENTS

See Abstract No. 1114

RECRUITMENT

1084. SOHLBERG, L. Här prövas något nytt för att lösa personalbristen. **[A new attempt to solve staff shortages.]** *Vårdfacket*, Stockholm, 1977, March 24, vol. 1, no. 6, pp. 16-18.

Shortage of hospital staff leads to overwork and dissatisfaction amongst the remaining employees, who then leave—a vicious circle. In order to break this circle, a project committee was set up at Skene Hospital (three hundred beds), with the aim of improving the working environment and altering the form of organisation. The working party consisted of a consultant, a secretary, a member of the management committee, the personnel manager, matron, two representatives of the town Patients' Association, and four elected staff representatives. A representative of the County Councils Association

and an adviser from Boraas County Central Hospital were also seconded to the committee. Conversations with ward staff revealed that a major source of dissatisfaction was the traditional ward round. Two-and-a-half-day ward-staff seminars were held in the autumn of 1975 to discuss alternative procedures, the major difficulty arising being the gulf between what one would like to alter and what is possible in practice in a rigid, traditional organisation. The ward round is now carried out by one doctor and one nurse, supplemented by a physiotherapist on Fridays; and certain jobs have been transferred from the night staff to days. But the main bonus is the improvement in the working atmosphere: there is less inter-category gossip and jealousy; bi-monthly staff meetings are held to discuss problems and try out new ways of tackling them; there is a greater sense of responsibility and awakened understanding of the task of management; and all staff now eat at the same place instead of being divided into small cliques for meals.

1085. GERMAINE, A. **Effective staff hiring calls for special skills.** *Hospital Administration in Canada*, Don Mills, Ont., 1977, March, vol. 19, no. 3, pp. 20-21, 23, 25.

The purpose of the interview is to determine the knowledge and skills of the applicant and to assess his/her temperament, maturity, and stability. Advice is given here to chief nursing officers on how to conduct an interview with applicants for nursing posts. The interviewer should not talk too much, should not try to impress, should not jump to conclusions, and should not ask leading questions. He should prepare a job analysis and job description and plan the interview in advance, conduct it in private, encourage the applicant to relax, and find out as much as possible about the applicant.

CONDITIONS OF SERVICE

See Abstract Nos. 1097, 1098

STAFF MANAGEMENT

See also Abstract Nos. 1084, 1093, 1099, 1100, 1115, 1121

1086. MARGERAND, P. La communication à l'hôpital et ses difficultés. **[Problems of communication in the hospital.]** *Gestions Hospitalières*, Mantes, 1977, March, vol. 164, pp. 227, 229-232, 235-238.

In the hospital problems of communication can be the result of defects in the administrative structure, of inadequate definition of the duties of the individual, of unsatisfactory human relations, or of too much, too little, or conflicting information. There is no easy solution, but the author suggests a number of measures which may offer some hope of improvement. These include the training of administrators and medical heads of department in management techniques, regular meetings between administrators, doctors, nurses, and general service staff, more in-service training, more delegation of responsibility with the object of enhancing job satisfaction, proper career structures, and the correct use of formal and informal channels of communication.

1087. SOHLBERG, L. Avdelningsmöten—en väg till bättre arbetsmiljö. **[Departmental meetings—a way of improving the working environment.]** *Vårdfacket*, Stockholm, 1977, March 24, vol. 1, no.6 pp. 18-19. ,

As part of its efforts to improve working conditions in 1975, the medical department at Skene Hospital introduced ward staff meetings every other month, in order to discuss problems arising. One of the first topics taken up was the afternoon temperature-taking. This was seen to be unnecessary, and was abandoned. The daily ward round is now practised by one doctor and one nurse, instead of being a large procession. Everything is now kept in the same place on the three wards, a measure which saves a great deal of time, particularly for night staff and temporary personnel. Most temporary staff have now been given permanent half-time posts (four per ward), with a staff pool covering the need for replacements. The fitter patients are encouraged to read to other patients, help staff with dressing people and at mealtimes, or take on a task from the 'jobs' board. Nurses are now called by their first names instead of their titles, and the rigid borderlines between job categories are being erased, since staff now have competence to do each other's jobs. Ward meetings are now rarer because problems are solved informally and are less frustrating than in the past. The only problem is that the rest of the hospital still works in the traditional way. The article is illustrated with a photograph of a ward meeting in progress.

STAFF RELATIONS

1088. JURIS, H. and others. **Nationwide survey shows growth in union contracts.** *Hospitals*, Chicago, 1977, March 16, vol. 51, no. 6, pp. 122, 124-125, 128, 130, 192.

Since 25 August 1974 when not-for-profit hospitals came under the National Labour Relations Act the number of contracts and employees covered by contracts have increased dramatically. The provisions and numbers of unions in health services are discussed. The background to the rise in union membership is considered, together with current union issues. The alternatives available to the union membership range from 'open shop' to mandatory membership. The provisions in union contracts are discussed, including payment of dues, payment for union work and notice to the union in disciplinary cases. The inclusion of strong provisions in a contract is a measure of union power. Increased union attention to union provisions can be expected in the hospital industry in the United States.

1089. ADJARIAN, M. J. Les réunions de surveillantes. **[Meetings of nursing supervisory staff.]** *Gestions Hospitalières*, Mantes, 1977, Jan., no. 162, pp. 33-40.

In most French hospitals the nursing supervisory staff have regular meetings with the management team. The latter view these meetings as a convenient means of informing the latter of decisions which have already been taken. This authoritarian approach is no longer acceptable to the nursing staff since no genuine dialogue can take place. The author suggests that these meetings should be replaced by three kinds of regular encounter: meetings for information, meetings for consultation, and meetings of working parties to consider specific problems.

STAFF TRAINING

See also Abstract Nos. 1091, 1101-1107

1090. SALKIND, H. M. **Hospital work-study program can redirect potential dropouts.** *Hospitals*, Chicago, 1977, March 16, vol. 51, no. 6, pp. 115-116, 118.

Prospect Hospital, Bronx (N.Y.), has established a work-study scheme which provides high school students with an opportunity to earn their diplomas, become interested in health care jobs through part-time, on-the-job training and be paid for their work while they are learning. Financial support was first received in 1975 and the salaries of 15 students were allocated for each term of the 1975-76 academic year. The aim of the scheme is to prepare students for jobs in hospitals and other health care organizations for which they will have been trained with little or no loss of earning power after graduation. Each student selects a specific department in which to work. The jobs include: office clerk; receiving and stores clerk; play therapy helper; nursing aide; medical record clerk; laboratory aide; dietary aide; health screening aide; cardiography aide; X-ray aide; maintenance helper; central supply helper; telephone operator; receptionist and information clerk; post-room clerk and pharmacy aide. A career structure is provided within each job. The social implications of the system are discussed. The future prospects in terms of employment are discussed. The scheme has been beneficial to the Hospital, since it now employs many people it trained under federal or state aegis years ago. All small hospitals should consider developing such training schemes as a contribution to their communities and a potential source of staff.

STAFF WELFARE

See Abstract Nos. 1108, 1116

SPECIAL CLASSES OF STAFF

1091. MOREAU, M. and LE TAILLANDIER, M. Évolution des formations des personnels des services de soins. **[Evolution of staff training in the health services.]** *Revue Hospitalière*, Paris, 1977, April, vol. 41, no. 300, pp. 323-344.

The majority of French nurses, nursing administrators, nursing aides, and medico-technical staff receive their training in public hospitals but this is true for only a small percentage of physiotherapists and midwives. In the île de France there is a shortage of nurses, particularly theatre staff and tutors, and of physiotherapists and radiographers. It is generally accepted that one of the functions of the public hospital should be the training of paramedical staff. The costs of this training are substantial, particularly if the hospital cannot retain its students once their training is completed. It is suggested that these costs might be borne on a regional basis. In-service training is briefly discussed and there are seven short annexes in which the number of students in training in the île de France and the number of vacant posts in the region are analysed, and the present status of the training of bio-medical technicians, and of nurses as anaesthetists' assistants is surveyed.

ADMINISTRATIVE AND CLERICAL STAFF

See Abstract No. 1122

MEDICAL STAFF

1092. MARSDEN, L. R. **Power within a profession: medicine in Ontario.** *Sociology of Work and Occupations*, Beverly Hills, Calif., 1977, Feb., vol. 4, no. 1, pp. 3-26.

Since 1969 there has been a universal health insurance scheme in Ontario, worked out on a cost-sharing basis with the federal government. Over a similar period, the gap has increased between doctors who teach and carry out research in the medical schools, and those who practise in the communities. The former have more influence over decisions affecting health matters, and the community doctors have become the 'clients' of the specialists. The Ontario Council of Health includes a high proportion of teaching doctors, who also control entry into the medical profession in Ontario. Although the government has financial control over medical schools in the universities, the advisory body to the government on the selection of students is more likely to reflect the views of the medical schools than those of the community practitioners.

1093. O'DONOVAN, T. R. **The physician as executive and leader.** *Royal Society of Health Journal*, London, 1977, April, vol. 97, no. 2, pp. 79-84.

As a manager the physician has received delegated authority to direct the activities of staff, including physicians and house staff, among others. As leader, this same physician becomes much more effective in moulding team work for maximization of patient care when he secures wilful co-operation from all his departmental staff. Every hospital-based physician has an executive and leadership role by the very nature of his position. This paper describes the model that fits the majority of American hospitals—one or more physicians have been delegated the authority to perform not only patient care activities, but also have a management role to oversee the overall direct patient care team. Some major examples of hospital physician-executives are chiefs of radiology, laboratories, physical medicine, and ambulatory services. The paper only considers those hospital-based physicians receiving part or all of their income from their hospital position. Aspects covered include the hospital-based physician as manager; overview of management; some advanced functions of management; the hospital-based physician as leader; intra-hospital relations; key leadership issues; democratic leadership: the leader as mature autocrat; bureaucracy in leadership; and cross-cultural conflicts.

NURSING STAFF

See also Abstract Nos. 1085, 1089, 1171, 1172, 1178, 1213

1094. BROWN, B. **The autonomous nurse and primary nursing.** *Nursing Administration Quarterly*, Germantown, 1976, vol. 1, no. 1, pp. 31-36.

The practice of nursing requires that the organizational relationships allow the nurse's relationship with individual patients to be as direct and undiluted by delegation as possible. This is only possible through primary nursing. Primary nursing has been used in implementing family-centred care at Family Hospital, Milwaukee, Wis. Such care is committed to dealing with patients' needs on three levels: the needs of the patient as an individual; the needs of the patient as a member of the family; and the needs of the total family that can be touched by the hospital. Each patient is assigned to his or her family care nurse upon admission to the hospital. The nurse has a direct

patient and family responsibility, and a 24-hour accountability to provide consultation, co-ordination, evaluation and direction of care throughout the hospital stay. Brief details are given of the nurse's responsibilities in documentation, teaching, discharge planning, the consultant role, research and problem solving. The organization for this system is outlined and the need for a transitional programme to allow the registered nurse to assume an autonomous role is emphasized.

1095. CHRISTMAN, L. **The autonomous nursing staff in the hospital.** *Nursing Administration Quarterly*, Germantown, 1976, vol. 1, no. 1, pp. 37-44.

The three major departments controlling the care of hospital patients, administration, medicine and nursing, can be placed in an organizational system which facilitates the role expression of each and eases communication between and among them. Other professional departments are needed in the care of patients, but they generally provide ad hoc services to the patient as the demand for their special services arise. To develop and implement an autonomous nursing staff system, the concept of parity, with all its implications, must be in central focus. An autonomous nursing staff is essentially an organization designed explicitly to permit: (i) the expression of clinical self-direction among nurses; (ii) the fulfilment of their responsibility to patients; and (iii) the acceptance of after-the-event sanctions rather than before-the-event controls over their practice. To implement their responsibility for the adequacy and safety of nursing care, nurses must use a process similar to that used by the medical staff. Some of the implications of developing autonomous nursing are discussed.

1096. HOCKEY, L. **Women in nursing: a descriptive study.** London, Hodder & Stoughton, 1976, 253pp. £5.95

A descriptive study about female nurses in four areas of Scotland, generated from nurses themselves who expressed concern about a variety of issues, many of which are specific to women. Aspects covered include: women as nurses; nurses as women; career patterns, job satisfaction; part time nursing, working hours; nursing auxiliaries; nurses' views on patient care; and top managers and their policies. The study methods are discussed. There are six appendices, including tables and a bibliography.

1097. ASHLEY, J. A. **Hospitals, paternalism, and the role of the nurse.** New York, Teachers College Press, 1976, xiv, 158pp. £2.95

This is a study of the development of nursing in the United States, exploring apprenticeship, and paternalism in the hospital setting from a historical point of view. The history of the development of nursing schools from charities to business organisations is discussed. The author argues that doctors and hospital administrators sought to economize on costs by apprenticing young women and constricting the role of nursing. Attempts to improve both the education and working conditions of nurses and the health of the public are discussed and the reasons why these efforts met with so little success. The author maintains that the misuse of the nurse's skills has a large part to play in the breakdown of the health care system. Notes on references and a bibliography are included (pp. 135-153).

1098. MONTESINOS, A. Les images de la situation de travail et de l'organisation du travail de l'infirmière. **[Impressions of working conditions and the organization of the nurse's work.]** *Gestions Hospitalières*, Mantes, 1977, Feb., no. 163, pp. 137-149.

The author, as part of his doctoral thesis, 'The Contribution of the Organization of Work to the Training of Nurses', analysed the contents of four French publications: 'Revue de l'Infirmière', 'Soins', 'Techniques Hospitalières', and 'Gestions Hospitalières', in three periods of two years, 1955-1956, 1964-1965, and 1973-1974, 1,912 articles in all, to identify the proportion of articles devoted to the nurse's work situation. He found 204 articles which dealt with various facets of the work situation, and the majority of these were concerned with its organizational, sociological, technological, and relational aspects. Eighty-two articles were written by nurses, of whom 46 had studied at schools for nursing tutors and administrators. Twice as many articles written by nurses were published in 1973-1974 compared with 1955-1956. This is seen as a sign of growing professional awareness and independence of thought among nurses.

1099. MEALY, S. and others. **Shared leadership—no head nurse!** *Nursing Administration Quarterly*, Germantown, 1976, vol. 1, no. 1, pp. 81-93.

As Family Hospital, Milwaukee, Wis., developed its programme of family-centre care using primary nurses [see Abstract No. 1094], it was found that all the nurses were able to assume organizational responsibilities. Ultimately this evolved into a system of shared leadership, with all family care nurses contributing to leadership responsibilities in the 35-bed general medical unit. This paper examines how the philosophy of the hospital and its nursing care system requires certain leadership responsibilities, briefly examines certain theories of leadership and how they may apply to the hospital's system, describes the evolution of shared leadership in the unit, and evaluates the advantages of the system over traditional nursing leadership organization.

1100. JONES, W. J. **Management by crisis or by objectives?—1.** *Nursing Times*, London, 1977, March 10, vol. 73, no. 10, pp. 342-343.

In the first of two articles the author explains the advantages of running a ward by patient allocation rather than by the traditional method of task allocation. The system achieves the objectives of a high standard of patient care and a high standard of nurse education. At the beginning of the day the student nurse is allocated a group of patients who become her responsibility for that day. She thus has the opportunity to learn through practice about the entire care and management of her patients and can even carry out complex procedures under the supervision or with the help of a trained nurse. A system of supervision is strictly adhered to and it makes great demands on the teaching abilities of the trained nurse on the ward. The ward sister must exercise considerable managerial skill, and the factors governing allocation of patients (the least ill to the most junior nurse, for example) are discussed. The author describes the implementation of a system of patient allocation in her own 24-bed female medical ward.

1101. SHEAHAN, J. **Curriculum development in nursing education. Part 4: Learning experiences.** *Nursing Mirror*, Sutton, 1977, April 14, vol. 144, no. 15, pp. 58-60.

Learning experiences in curriculum development should be first-hand where possible.

The main elements in the learning process are the collection of information; cognition; actualisation; validation; and synthesisation. The variety of approaches to attitude development are discussed. These include models, group discussions, role-playing, and discovery learning. The curriculum should provide opportunities for the students to put their knowledge and experiences to use. The choice of teaching method is important; formal teaching methods can be used in conjunction with inquiry-based learning to add variety and present a basis for individual study. Learning aids and learning resources should also be considered and used to serve particular functions within the curriculum.

1102. SIMS, A. **Modular systems of nursing education, adapting to limitations.** *Journal of European Industrial Training*, Bradford, 1977, vol. 1, no. 2, pp. 28-32.

The education of nurses has moved from the situation when student nurses could attend lectures in their own time, to a study day system and a block system. The background and structure of nursing education in England and Wales is discussed. The idea of specific modules following a broad-based training developed from grievances relating to the block system. The new recommended structure based on the modular system is discussed. A feasibility study was carried out at four hospitals. The objectives of the study are discussed, together with the back-up facilities necessary to support and produce the best form of modular scheme. The teaching methods and learning opportunities arising as a result of the scheme are analysed. The modular scheme produced a greater degree of homogeneity compared to the block system. The effects on staffing and the constraints staffing placed on the educational process were evaluated. Teachers and students were similarly enthusiastic about the scheme. The advantages and disadvantages of the modular method are discussed. However, a greater initial commitment on the part of hospitals, resulting from a more gentle introduction to the scheme, might well have reduced many of the problems.

1103. TOWNSEND, I. **Space and equipment requirements.** *Nursing Times*, London, 1977, April 28, vol. 73, no. 17, pp. 617-618.

This paper outlines the space and equipment requirements for a learning resources centre to be developed in three phases: (i) initial basic stage where the centre is concerned with identification and organization of resources, serving staff rather than students; (ii) ideas about the nature of student learning via resource units are put forward, tested and modified in the light of practice; and (iii) curricular modules are offered as discrete entities, in an independent-individualized format and the centre is used as an integral part of staff strategy for teaching.

1104. CROSBY, M. H. **Teaching strategies: a microteaching project for nurses in Virginia.** *Nursing Research*, New York, 1977, March/April, vol. 26, no. 2, pp. 144-146.

Microteaching, a teaching encounter scaled down in size and time, enables students to practice specific desirable components of teaching outside the complex classroom situation. It normally centres on a teaching laboratory where videotape recordings are used to provide immediate feedback of the performances, allowing self-criticism as well as criticism by other participating students and the instructor. Classes typically consist of six to 10 students and sessions last 10 to 15 minutes. The method was used for a

graduate course on teaching strategies at the University of Virginia School of Nursing. The teaching behaviour of 57 students who attended the course was rated using the project's rating scales. All students showed significant positive increases in teaching behaviour on pre-, mid- and post-course measures in lecture discussion and group discussion teaching modes. Additional measures of the students' teaching indicated retention of the learned behaviours six months after completion of the course.

1105. THOMAS, B. **Differential utility of predictors in graduate nursing education.** *Nursing Research*, New York, 1977, March/April, vol. 26, no. 2, pp. 100-102.

A five-year study of a sample of 198 graduates from four masters' programmes (medical-surgical nursing, children's nursing, psychiatric nursing and nursing service administration) at the University of Iowa examined the problem of predicting success in graduate nurse education. Results of the students were analysed to determine the efficiency of the traditional predictors (undergraduate grade point average and graduate record examination scores) in predicting success in graduate education as measured by the masters grade point average. The findings included support for the use of these predictors in the selection of graduate students and evidence that inter-programme differences existed, indicating a need for different selection practices for the different courses.

1106. RICHARDS, M. A. **One integrated curriculum: an empirical evaluation.** *Nursing Research*, New York, 1977, March/April, vol. 26, no. 2, pp. 90-95.

In a three-year study, Harris College of Nursing, Texas Christian University, Fort Worth, compared graduates from its old block curriculum with those from the first two years of a new integrated curriculum (the first year being a transitional curriculum). The object was to find out whether the courses were, in fact, producing professionals. It was found that graduates of the integrated curriculum tended to possess a higher degree of leadership and empathic ability without sacrifice of knowledge, but less critical thinking ability than students graduating from the older curriculum. It is suggested that this might have resulted from too much consistency of approach in the integrated course. Intellectual characteristics (IQ, scholastic aptitude scores, critical thinking ability) plus leadership potential and empathic skill were significant in discriminating between successful and unsuccessful students.

1107. GREAT BRITAIN. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. **Directory of schools of nursing with pre-basic, basic and post-basic nursing and midwifery training schemes, and educational and career opportunities. 3rd edition.** London, **Her Majesty's Stationery Office**, 1977, vii, 374pp. £6.75

The third edition of this directory—the first to be compiled by the Department of Health and Social Security—provides information on pre-basic and basic nurse training; also on midwifery; district nursing; health visiting; occupational health nursing; ophthalmic, orthopaedic and thoracic nursing; post-basic clinical courses; courses for nurse tutors and clinical teachers; and post-basic opportunities in further and higher education. A list of schools of nursing and other educational establishments offering courses of training is included together with a list of organisations and individuals from whom further information can be obtained.

1108. MOORES, B. and GRANT, G. W. B. **Feelings of alienation among nursing staff in hospitals for the mentally handicapped.** *International Journal of Nursing Studies*, Oxford, 1977, vol. 14, no. 1, pp. 5-12.

As part of a study concerned with the direct and indirect effects of different nurse staffing levels on the patterns of patient care, an attitude questionnaire was developed. During the course of developing the questionnaire it became obvious that nursing staff held strong views about various organizational characteristics of their hospitals. Numerous pilot versions of the document contained comments, and the majority related to the extent to which the respondent felt that her views were either not solicited or heeded when important decisions were taken with respect to patients. It was therefore decided to incorporate questions related to this issue in the final version of the questionnaire. A total of 686 usable questionnaires were returned from 33 hospitals for the mentally handicapped. The results are presented in seven tables and two diagrams. They reveal substantial differences between hospitals in the extent to which staff feel involved in decisions relating to patients and that these feelings are shared by all grades of staff. These results could reflect the real extent to which staff are or are not involved in such matters. Alternatively they could reflect some other underlying basic feeling of discontent which finds its manifestation in this matter. In either case something needs to be done in those hospitals scoring badly on this attribute.

1109. BRIGID, M. **Nursing professionalized: a change process in Iowa hospitals.** *Hospitals*, Chicago, 1977, Jan. 16, vol. 51, no. 2, pp. 81-82, 85.

Iowa Hospital Association set out to determine how organizational changes could be carried out in Iowa hospitals in order to make better use of the skills and time of professional nurses without increasing numbers or costs. A project to improve the quality of nursing care by helping nurses make better use of their time and abilities was carried out over a three-year period in six hospitals. The project, Nurse Utilization Research Study and Evaluation (NURSE), was designed around two assumptions: (i) effective patient care requires the development of specialized nursing roles; and (ii) successful change requires internal commitment. The existing conditions and objectives for change for each of the six hospitals are summarized. A framework was used to measure each hospital's progress. The results indicated that as a whole the demonstration hospitals improved in all areas of professional nursing, whereas control hospitals improved only in the increased use of patient-teaching aids. The survey revealed that while there was no significant increase in cost in these hospitals there was an increase in the quality of nursing care. In view of the conclusions it appears that many hospitals are ready for and should be given the necessary help to reprofessionalize nursing.

1110. STEPHENS, D. S. B. and BOALER, J. **The nurse's role in immediate post-operative care.** *British Medical Journal*, London, 1977, May 7, vol. 1, pp. 1199-1202.

From the time that a patient leaves the care of the anaesthetist after an operation until he wakes in a ward his physiological state should be continuously and expertly supervised. Post-operative nurses are provided only when the operating theatre has a recovery room. A survey among consultants and nurses in the South East Thames

Region showed that many surgical units did not have recovery rooms and that inexperienced ward nurses were often sent to collect patients. The survey revealed that most nurses were competent to care for unconscious patients so long as an emergency did not arise. In many hospitals the facilities for the safe nursing of post-operative patients were totally inadequate. A fully equipped recovery bay or area close to expert help is mandatory in all busy surgical units. There should be good communications, lighting, and a source of oxygen and suction. One post-operative nurse should be provided for every one patient, or at the most two patients. Because of the shortage of nurses it would be realistic to recognise that trainee nurses are likely to have to care for post-anaesthetic patients early on and train them accordingly. Recovery nurses should be appointed for all busy surgical units, and there should be close co-operation between anaesthetists and nursing tutorial staff to ensure that the training programme fulfills the requirements.

1111. MOORES, B. and GRANT, G. W. B. **Optimists and pessimists: attitudes of nursing staff towards the development potential of mentally handicapped patients in their charge.** *International Journal of Nursing Studies*, Oxford, 1977, vol. 14, no. 1, pp. 13-18.

As part of a broader research study [see Abstract No. 1108] efforts were made to measure the attitudes of nursing staff to the potential level of patient accomplishment. The results demonstrate two equally disturbing facts. Firstly, it appears to be the case that many nursing staff, particularly the less well qualified, still hold pessimistic views about what their patients can achieve. This would seem to indicate that a considerably enhanced in-service educational activity is needed for nursing assistants and that the more formal training programmes for student and pupil nurses require the input of material related to this general theme of potential. Secondly, the differences between institutions indicate that one hospital is apparently more successful than another in attracting optimists. Presumably the process is contagious in that once a hospital has a disproportionate number of pessimists it is more than likely that those with optimistic leanings will be less inclined to stay.

1112. MORGAN, R. **Must the ward mental nurse remain confined to the ward?** *Nursing Mirror*, Sutton, 1977, May 5, vol. 144, no. 18, pp. 63-64.

The structure and organization of nursing services in psychiatric hospitals are modelled in many ways upon the general hospital pattern, although the job and the customers are very different. In the psychiatric hospitals patients are only incidentally ill, and very few, if any, benefit from rest in bed. The deployment and ward-oriented attitudes of most nurses has remained the same in spite of the changes in the pattern of the psychiatric patient's life. The traditional pattern of ward oriented nursing fails to reconcile the principles of: the better the ward the more empty it should be during working hours; the right place for the nurse is to be with his or her patients; and the greater the nurses' experience and training the more he or she has to offer to patients. The re-opening of a second-hand hospital provided an opportunity for developing a new system. Each trio of three bedded wards possesses its own workshop and it is to wards and workshop that nurses are assigned. Sick patients are placed in a clinic or sick bay staffed separately from the wards, which provides an in-patient and out-patient service for the patients. The advantages of the existence of the clinic are dis-

cussed. Communication has improved and a healthier image affects the patients themselves since they are now no longer identified as being ill unless they are actually in the clinic.

1113. O'Brien, S. E. M. and Stoll, K. A. **Attitudes of medical and nursing staff towards self-poisoning patients in a London hospital.** *International Journal of Nursing Studies*, Oxford, 1977, vol. 14, no. 1, pp. 29-35.

Sixty members of the medical and nursing staffs of a London teaching hospital were asked to complete a questionnaire designed to elicit information on their attitudes towards overdose patients and their care. They were also asked to examine the case for a specialized 'overdose' ward. The results are summarized in three tables and discussed under the headings: (i) the attitudes of staff towards overdose patients; (ii) care of the patient; (iii) the case for a specialized ward; (iv) problems of medical management; (v) psychiatric support and staff attitudes; and (vi) overdose patients' relationships with other patients. The case for a specialized ward would appear to be a strong one in terms of medical and psychiatric care for the overdose patients. It has received a great deal of support from medical and nursing staff. It remains to be seen whether there can be a satisfactory redeployment of restricted resources to enable the concept to be translated into reality.

1114. Hambleton, B. **Staffing inflation.** *Nursing Mirror*, Sutton, 1977, May 5, vol. 144, no. 18, pp. 68-70.

The significant changes which have occurred since 1966 and their effects upon nursing staff establishments in psychiatric hospitals are discussed. The recommended staffing levels put out by the Department of Health and Social Security are questioned for their validity. The major changes in institutional in-patient care, day patient care and out-patient and community nursing services have resulted in a marked increase in cost to the nursing establishment. Changes in nurse education have had considerable impact on nursing establishments and not all these changes have been precisely costed in management terms or reflected in staffing levels. The cost of post-basic training is discussed. The effect of the revised conditions of service laid down by the Whitley Council is outlined. The current system encourages negative concepts in psychiatric nursing and discourages positive therapeutic change because of its staffing consequences. The only equable method of determining a nursing staff establishment in a psychiatric hospital is to analyse the nursing needs of each department and convert the needs into a balanced establishment. The method provides a disciplined analysis of the total situation which can be readily updated as future changes take place. The fixed-ratio method of establishment setting prevents flexible responses to individual innovation and encourages staffing inflation.

1115. Brown, B. J. **The role of nursing administrator in patient care delivery systems.** *Nursing Administration Quarterly*, Germantown, 1976, vol. 1, no. 1, pp. 1-6.

The basic role of every professional nurse has four major components: service, education, research and consultation. In addition to assuming and having the capability to perform this basic role, the nurse administrator's role is one of a multi-faceted role-model for all her staff. She must set budget and fiscal priorities, develop and

integrate the goals of all professional nurses, provide leadership, act as a communicator between administration and staff, safeguard legal and human rights, assess the achievements and problems of the nursing services, and participate actively in medical staff conferences concerned with patient care.

1116. HURWITZ, A. and EADIE, R. F. **Psychologic impact on nursing students of participation in abortion.** *Nursing Research*, New York, 1977, March/April, vol. 26, no. 2, pp. 112-120.

Dreams were used to ascertain the psychological impact on first-year nursing students of participation in abortion and of other educational experiences. Stressfulness of the experiences was measured by the number of dreams, recurrence of dreams and content analysis of the dreams during four one-week data gathering periods, one of which was a vocation. It was found that dreams tended to be more negative during stressful periods. The abortion experience was found to be more stressful than other experiences encountered during the four periods.

ORGANIZATION AND ADMINISTRATION

See also Abstract Nos. 1144, 1210, 1214

1117. SHALIT, S. S. **A doctor-hospital cartel theory.** *Journal of Business*, Chicago, 1977, Jan., vol. 5.0, no 1, pp. 1-20.

The accreditation of any hospital in the United States depends upon the organisation of the medical staff into a quota-allocating type of cartel which ensures that no doctor exceeds his quota of hospital work or works outside his specialty, thus protecting the quality of care given to the patient. However, the 'local' cartels can attempt to control the supply of hospitals available to doctors in order to maximize the doctor's income. The theory is put forward in this paper that the cartel model could be used to allocate hospital resources, and indeed to control the supply of hospitals. Doctors could buy from the cartel a number of beds at a price high enough to channel the greatest number of beds to the greatest number of doctors, provided a profit-making maximum was set. An empirical test is described which was found to be consistent with the theory.

1118. ALLEN, A. O. **Management improvement on a broken shoestring.** *Hospitals*, Chicago, 1977, Feb. 16, vol. 51, no. 4, pp. 64-66.

The 228-bed Arthur C. Logan Memorial Hospital is a private, voluntary facility in the heart of a ghetto in New York City. It is in a precarious financial situation for reasons which are detailed. It also had other difficulties resulting from not using effective management principles and practices. Despite many problems and objections a management improvement programme was instituted. The strategy was to present the fundamental principles, concepts and techniques of management in a series of eight seminar-workshops, with the emphasis on achieving immediate improvements in the day-to-day performance of the participants. The programme was given first to the executive council, then department heads and then first-line supervisors. A firm of management consultants specializing in the health and social field established and conducted the programme, provided coaching and guidance to participants and

assisted in the application of the new concepts in the daily activities of the supervisory staff. Some examples are given of the improvements achieved.

1119. CENTRE DE RECHERCHE SUR LE BIEN-ÊTRE. Pratiques medicales et système hospitalier. **[Medical techniques and hospital administration.]** Paris, CEREBE, [1976], [iv], 114pp.

This long report from the CEREBE (Welfare Research Centre) examines the contention that specialisation in medicine is growing at the expense of the chronic sick, the old, the psychiatric patient, and the rural hospital. It traces the development of medicine from the clinical medicine of the 19th century to specialisation, and from specialisation to the medicine of advanced technology, and uses a psycho-socioeconomic approach to examine in depth the inflationary process of hyperspecialisation and the conflict between medical and economic objectives in the hospital. The authors suggest two scenarios for the future; the first is a linear model in which the present system becomes institutionalised, general medicine and surgery disappear, and departments become even smaller and more specialised. The second scenario envisages a complete break with present trends and a return to the predominance of general medicine. The empirical results, statistics and methodology employed in the report are published separately, but this volume contains a bibliography which includes 100 references.

1120. BARBER, B. **Operational research and implementation at the London Hospital.** *European Journal of Operational Research*, Amsterdam, 1977, March, vol. 1, no. 2, pp. 79-83.

The Operational Research Unit at the London Hospital was set up in 1966 as a pioneering venture. This paper describes some of the work carried out by this Unit on out-patient clinics, emergency anaesthetic services, haemodialysis and transplant programme, and the development of hospital computing and operational research. The work highlights the degree of participation required for successful implementation within a multidisciplinary hospital context.

1121. DREXLER, A., YENNEY, S. L. and HOHMAN, J. **OD: coping with change.** *Hospitals*, Chicago, 1977, Jan. 1, vol. 51, no. 1, pp. 58-60.

Organization development (OD) is a relatively new technique for achieving long-range goals and is derived from complex industrial models that have few structural characteristics in common with health care organizations. OD concepts draw heavily on organization behaviour theory; interpersonal and group dynamics; open system planning; general system theory and Gestalt theories. The American Hospital Association (AHA) has used OD as a method of obtaining a more flexible co-ordination of resources in order to enable it to respond more readily to the complexities of multiple demands. The background to the AHA organization is outlined. Other management methods that were considered included: internal reorganization; scientific management; and training programmes. The relative merits of each scheme are discussed.

1122. FARRELL, N. L. and LACOSTA, C. J. **Unit administration updated.** *Hospitals*, Chicago, 1977, Feb. 16, vol. 51, no. 4, pp. 75-76, 78.

New York Hospital started a unit administration programme in 1948; it was

primarily a programme of the nursing service which first experimented with pavilion managers to help ease the increasing work load of the head nurses on a few floors. In 1970, an additional layer of management staff were hired by the nursing service to supervise the pavilion managers and to assist the head nurses. By the end of 1973 it had become clear that the system needed evaluation and reconstruction. There were 21 in-patient administrators responsible for the overall operation of their units with respect to all indirect patient care activities. They supervised pavilion clerks and pavilions. The pavilion managers, each responsible for two patient floors or 60 beds, were usually long-term hospital staff who were originally employed as nursing aides or pavilion clerks. The main differences between this system and the new one installed as a result of the review were the staffing levels and the expected performance levels of the in-patient administrators. Each one was made responsible for a unit of 100 beds. This reorganization presented a great challenge to the pavilion managers. A more thorough performance evaluation and a new training programme for the pavilion clerks were devised.

ECONOMICS OF HOSPITAL MANAGEMENT

See also Abstract Nos. 1117, 1138, 1151, 1184, 1208

1123. BENNETT, A. C. **Results must be evaluated in measurement of success.** *Hospitals*, Chicago, 1977, March 16, vol. 51, no. 6, pp. 109-110, 112.

The quality of hospital management should be considered in a context that recognises that: the role of management is changing; 'profitability' cannot be the sole measure of the success of an organisation; actions and good intentions should not be confused with accomplishments; the need to establish standards of performance is a critical aspect of the hospitals system; and the health care manager should be accountable for his actions. Suggestions are offered about the methods in which organisation and management might develop towards the ideals of: self determination; non-conformity; interdependancy; open communication; flexibility, and humanistic environment. The framework for assessing success should include: good objectives; measurable standards and objectives; performance criteria; management information systems and performance review and appraisal processes.

1124. ANDERSON, J. G. **A social systems model of hospital utilization.** *Health Services Research*, Chicago, 1976, vol. 11, no. 3, pp. 271-287.

A social systems model for the health services system serving the state of New Mexico is presented. Use of short-stay general hospitals is viewed as a function of sociodemographic characteristics of the population and of the supply of health manpower and facilities available to that population. The model includes a network specifying the causal relationships hypothetized as existing among a set of social, demographic and economic variables known to be related to the supply of health manpower and facilities and to their use. Inclusion of feedback into the model as well as logged values of physician supply variables permits examination of the dynamic behaviour of the social system over time. A method for deriving the reduced form of the structural model is presented along with the reduced-form equations. These equations provide valuable information for policy decisions regarding the likely consequences of changes in the structure of the population and in the supply of health manpower and facilities. The

structural and reduced-form equations have been used to predict the consequences for one New Mexico county of state and federal policies that would affect the organization and delivery of health services.

1125. BERTHOMME, H. and others. Les effets d'échelle dans les hôpitaux. **[The effects of scale in hospitals.]** *Gestions Hospitalières*, Mantes, 1977, Jan., no. 162, pp. 27-31.

The results of two French studies have shown that scale has no effect on costs in hospitals, while another French study and an American one have shown that the opposite is the case. The methods used in these four studies are described. It is suggested that the best way to calculate the effect of scale on cost would be to develop a means of measuring the hospital's health product or, failing this, a method of measuring the activity deployed by the hospital to produce this quantity of health. The optimum scale in economic terms may not be the best socially and psychologically.

1126. ELLIS, B. **Energy management: it's dollars and sense.** *Hospitals*, Chicago, 1977, March 16, vol. 51, no. 6, pp. 159-160, 162, 164.

A total management plan established at Lutheran General Hospital, Park Ridge, Ill., has successfully reduced energy consumption by 14 per cent, resulting in substantial savings in cost. The search to eliminate wastage covered all areas of the hospital. Ventilation was shut down or reduced in many areas, boiler efficiency monitored, and water temperature reduced throughout the hospital by two degrees except in the kitchen where the temperature was retained at 180°F. An integrated approach to extend the scheme to all areas is essential. Each building should be considered in the light of how it consumes energy, how users needs are met and how systems interrelate. Many of the significant savings in this hospital were the result of little or no capital investment. The key to the scheme appears to be a common sense approach, constant re-evaluation, and a thorough knowledge of hospital plants and activities.

1127. GRIMES, R. M. and MOSELEY, S. K. **An approach to an index of hospital performance.** *Health Services Research*, Chicago, 1976, vol. 11, no. 3, pp. 288-301.

Two indexes are described, based on measures of administrative effectiveness and patient care effectiveness. The measures used were selected and ranked by a Delphi panel from a list of 30 measures drawn from the literature. Weights were assigned by the panel to 19 selected measures. The indexes were used in 32 Texas hospitals for studies of performance and with further testing and refinement may be a useful adjunct to hospital classification schemes aimed at cost control or quality standardization.

BED OCCUPANCY, ECONOMIC USE OF BEDS

See also Abstract Nos. 1174, 1188, 1209

1128. THOMAS, D. E. and STOKES, H. H. **How many beds should a hospital department serve?** *Health Services Research*, Chicago, 1976, vol. 11, no. 3, pp. 241-251.

Data from the semi-annual Hospital Administrative Service reports of the American Hospital Association were used to construct departmental cost functions for selected hospital departments, using total number of beds in the hospital served as a proxy

output measure. Calculation of maxima or minima for the resulting cost functions reveals that, on average, different departments have extremes in their cost functions at different levels of output. A relative cost index is constructed, using parameters of the departmental cost functions, and departmental costs are compared across regions. The significance of departmental differences in optimum output is discussed with regard to sharing of services and modified system design.

1129. RICHEL, W. and SAJDA, L. **Performance factor developed as surgical suite management tool.** *Hospitals*, Chicago, 1977, March 16, vol. 51, no. 6, pp. 146, 148, 152.

A composite utilization figure was used at Long-Island Jewish-Hillside Medical Center, New Hyde Park, New York, to measure surgical department performance, in order to obtain maximum use of the department to accommodate demand without expanding facilities. In 1976 the average waiting period for patients requiring urgent surgery was seven days and for those requiring elective surgery it was six weeks. A performance factor to provide a measure of all requirements and to overcome the inherent limitations was established. The factor first evaluated those items that could be controlled by the surgical department management. The performance factor approaches 100 per cent when members of the team are available when they are needed, working at a normal pace. Additional benefits have developed through the production of a computer program to generate a performance report. Average performance times can be used for the scheduling of work in the surgical suite. The administrators can calculate the actual work load of the surgical department and the use of the information has proved useful in evaluating overtime and additional staffing for increased work loads.

DATA PROCESSING

See Abstract Nos. 1131-1134, 1164, 1177, 1183, 1189

LIBRARIES

1130. FARMER, J. **Medical librarians in the patient care setting.** *Library Association Record*, London, 1977, Feb., vol. 79, no. 2, pp. 81, 83, 85.

The provision of information for those who need it most, i.e. the members of the clinical team in the large teaching hospital, presents problems for the library staff. The author visited three centres in the United States where clinical librarianship programmes have been introduced so that information requirements can be identified and a user-oriented information flow established. The clinical librarian accompanies the clinical team on their rounds to out-patient clinics, and to patient conferences and departmental meetings and lectures. He is then in a position to initiate immediate manual or computerised literature searches for the data required to answer specific questions raised by a member of the clinical team. Some questions recur frequently and patient care information systems are being set up at two of the three centres. An experienced clinical librarian can identify information needs with 90 per cent or greater accuracy. In a programme of this nature the clinical librarian can act as an interface between the practitioner and the large quantities of information available, and can also improve the information-seeking skills of the clinical team.

1131. SCHAAD, R. and SWERTZ, P. **HECLINET—Health Care Literature Information Network.** *Methods of Information in Medicine*, Stuttgart, 1977, April, vol. 16, no. 2, pp. 103-105.

In 1970 the hospital centres in several European countries established a working party to co-operate in the information field; in 1973 it was formalized as the Study Committee on Information and Documentation of the International Hospital Federation. A survey by the committee of 20 institutions in 14 different countries revealed wide differences in documentation techniques and considerable duplication of effort. The German Hospital Institute and the Institute for Hospital Building of the Free University of Berlin have been trying for some years to develop a scheme for indexing the national literature in the various countries and processing it on a central computer. Ten other countries are now participating in the scheme. The Swiss and Danish hospital institutes are now using the German tapes and the Centre for Hospital Science, Leuven, Belgium, and the Austrian Federal Institute of Health are now connected on-line to the German computer. The linguistic problems constitute a barrier to co-operation, but several multilingual thesauri have been or are being developed. The possible future development of HECLINET and co-operation with Medlars, Excerpta Medica and EURONET are outlined.

ORGANIZATION AND METHODS, WORK STUDY

See Abstract Nos. 1120, 1172

MEDICAL RECORDS

See also Abstract Nos. 1189, 1206, 1207

1132. OWEN, E. W. and MOSELEY, E. C. **A user-compatible terminal for medical applications.** *Computers in Biology and Medicine*, Oxford, 1977, April, vol. 7, no. 2, pp. 165-178.

A computer terminal has been designed that is adapted to the characteristics of medical staff and compatible with medical record keeping. The input device is an electronic tablet rather than a keyboard, and information is entered into the medical records system by means of charts and checklists. Small handwritten notes are accepted and their storage and retrieval automated. A small, lightweight television screen is used as the output device. The advantages of the tablet allow handwritten input and the extended use of checklists and charts, and also greater ease of carrying. The problems of digitized handwriting are discussed. The considerations behind the development of the terminal are discussed and the design and technical features described.

1133. Nieuwe apparatuur in Holy-Ziekenhuis te Vlaardingen: video-systeem voor patiëntenbewaking geeft meetgegevens ook in getallen: kortere ligduur in intensive care van Dijkzigt. [**A new patient-monitoring video system, showing data in numerical as well as graphic form, is now in use in the intensive care unit of the Holy Hospital, Vlaardingen. In the intensive care unit of the Dijkzigt Teaching Hospital, Rotterdam, shorter patient bed-stay has resulted from the use of a similar system.**] *Technische gids voor Ziekenhuis en Instelling*, Amsterdam, 1977, March 21, vol. 46, no. 1120, pp. 122-123, 125.

With the 'Philips' video system the data, both graphic (e.g. electrocardiogram) and numerical (e.g. pulse), is shown on four screens in the monitoring station in the centre of the new 11-bed intensive care unit in Holy Hospital. In addition each bed carries a small monitoring screen. A hard copy of the data at a particular moment for later interpretation can be printed at any time and is automatically provided with patient's identification, time and date. Electrocardiogram, pulse, temperature, various blood pressures and respiration can be measured continuously, each by separate modules, together presenting the patient's monitoring system. They are fixed in a suspension unit above the bed, which also includes supplies for electricity, oxygen, working lights etc. The modules can be set at danger levels with warning signals in light or sound when the limit is reached. There are plans for a similar system to be introduced in the incubator unit. Dijkzigt Hospital recently introduced in its nine-bed intensive care unit a similar system including a trend-recorder to record progress of treatment. It was found that once staff became familiar with the improved technology the result was a shorter bed-stay for the patients. The paper includes three pictures.

1134. ST. CLAIR, C. and others. **Computerizing a mental health center information system.** *Administration in Mental Health*, Rockville, Md., 1976, vol. 4, no. 1, pp. 10-18.

This paper describes the administrative, research, clinical and technical inputs needed to establish a computerized management information system in a large and complex community mental health centre. Problems and issues specific to each phase of the operation are discussed. The phases and the period in which they were carried out were: planning phase (winter 1973-1974); designing the input documents (spring 1974); preparing for conversion to a computerized system (summer 1974); implementing the conversion and designing the output documents (September 1974); monitoring the conversion process (October 1974); beginning the computerized system (November 1974); receiving outputs and entering remaining inputs (winter 1974-1975): and the final stages (spring 1975).

LEGAL ASPECTS OF HOSPITAL ADMINISTRATION

See Abstract No. 1193

FINANCE AND ACCOUNTING

FINANCE

See also Abstract Nos. 1128, 1175, 1200

1135. SHARP, N. and MILANI, K. **Hospital budgeting.** *Management Accounting*, New York, 1977, March, pp. 49-52.

Budgeting is defined as a managerial activity which focuses on accounting information that is needed to effectively operate and understand an organization. Preparation of a budget involves many people who must be given the responsibility and authority to carry out their task. The chief financial officer normally serves as the budget director and a budget committee is responsible for the co-ordination of all the activities involved in budget preparation. A budget calendar (an example of which is reproduced) assists

the co-ordination of activities, ensures that departmental budgets are received on time and alerts departmental heads to what is expected and when. The operating budget details the work and spending plans for the next year. Within it are three distinct budgets: statistical, expense, and revenue. The contents of and procedures for each of these are outlined. In addition, a cash budget is prepared to ensure that there will be enough cash on hand to meet expenses. Monthly reports by department comparing actual with budgeted figures are essential for adequate budgetary control. Today's hospital budget must be consulted and used in daily operations, and the information it contains must be based on much more than just past experiences.

1136. KING, D. D. **Cost reductions curb impact of declining census.** *Hospitals*, Chicago, 1977, Jan. 16, vol. 51, no. 2, pp. 107-108.

In 1976 the Medical Center of Central Georgia, Macon, experienced such a decline in patient numbers that it required a massive cost reduction scheme. The centre was able to carry out its cost reduction exercise, whilst maintaining good staff, doctor and community relations, by developing an overall scheme, and good communications with the board of trustees, staff and community. The scheme involved: (i) a freeze on recruiting staff, except when specific patient service coverage was required; (ii) reduction in cost of supplies by reducing the supply inventory; (iii) reduction in costs of utilities by checking lighting, establishing temperature control and auditing telephone use; and (iv) reduction in the size of the payroll, by reducing the number of hours worked. Methods of communicating with the staff are outlined. The success of the scheme resulted in the financial position of the hospital improving within 60 days. The centre continued to meet the needs of its patients and maintain its staff whilst conducting a successful cost reduction scheme.

1137. LARSEN, T. Les dépenses hospitalières dans certains pays de la Communauté Économique Européenne en 1971 (1969). **[Hospital costs in certain hospitals in the European Community, 1971 (1969)].** *Gestions Hospitalières*, Mantes, 1977, March, no. 164, pp. 211-214, 216-218.

This article summarises a report on hospital expenditure in EEC countries prepared for the Commission by M. C. Michel in 1973. The data on which the report is based are incomplete; moreover, the data from the original six member countries relate to 1969 while those for the three new members relate to 1971. The author has thus selected data relating only to Denmark, West Germany, France, Italy, the Netherlands, and the United Kingdom. He provides a brief commentary to four tables and five graphs which compare expenditure on health and hospital services for 1961 and 1971 (1969) as a percentage of GNP, numbers of admissions to hospital per 1,000 population, length of stay, number of hospital beds per 1,000 inhabitants, bed occupancy, and number of staff per bed. Expenditure was highest in Denmark and lowest in Italy. Italy had the highest number of doctors per 1,000 inhabitants, and the Netherlands the lowest number of admissions. The average stay in hospital was longest in the Netherlands (20.7 days) and in the United Kingdom (20 days) and shortest in Italy (14.0).

1138. PHILLIP, P. J. **Two new AHA indexes measure costs, intensity.** *Hospital Financial Management*, Chicago, 1977, April, vol. 31, no. 4, pp. 20-22, 24, 26.

To reflect more accurately the pressures forcing hospital costs to rise, the American

Hospital Association recently announced two new measures: the hospital costs index (HCI) and the hospital intensity index (HII). This paper traces some of the reasons for the prevailing misunderstanding of hospital cost trends and then introduces the two new measures. The indexes are constructed from 37 service elements provided per patient day; the elements include primary inputs such as nursing, housekeeping and administrative manhours, and secondary inputs (or intermediate outputs), such as tests, procedures, drugs and meals. The construction of the indexes is described and their advantages are discussed.

1139. HITT, D. H. **Reimbursement system must recognize real costs.** *Hospitals*, Chicago, 1977, Jan. 1, vol. 51, no. 1, pp. 47-53; Jan. 16, vol. 51, no. 2, pp. 69-70, 72, 75-77.

The inadequacies of the present hospital financing system in the United States are clearly evident yet the hospitals are not addressing themselves to the problems of possible long term solutions. The present disjointed payment system should be replaced by a nationally acceptable, co-ordinated perspective rate system that promotes economical management and planning, discretionary allocation of resources, and public support for the system. The opportunities for making this change are discussed. However, the goals can only be met through budget review and approval by an independent state agency under carefully developed federal guidelines. Industry should take the initiative for carrying out change in the hope of avoiding the spread of arbitrary rate promulgation. The support by the hospital field of a pluralistic system of payers is discussed. A controversial issue is whether all payers should pay the same charges. Other issues include unit of service based on 'per patient day' and 'per-case'. The deficiencies of 'simple' methods of payment are outlined. The 'financial requirements' of the American Hospital Association (AHA) are discussed in the light of their policy of asking for capital financing only for facilities and services approved by planning agencies. 'The Statement on Financial Requirements for Health Care Institutions and Services' produced by the AHA is discussed. Hospitals have a duty to preserve their capacity to serve community needs and should have included in their charge for services an element that could serve as profit. The public responsibilities of the health care industry are outlined. The importance of capital to the hospital and the need to borrow at reasonable interest rates is considered. The question is no longer whether the health service industry will be regulated but how it will be regulated. If the hospital field does not act soon regulations devised by others will govern its priorities and interests, probably without a discretionary process, formal structure or appeals mechanism. Hospitals should agree on the best system for the future and put it into action before national health insurance reaches full proportions.

HOSPITAL ACCOUNTING

1140. ALLCORN, S. **Internal audit function can improve health care delivery.** *Hospitals*, Chicago, 1977, Jan. 1, vol. 51, no. 1, pp. 54-57.

The development of the use of the hospital for the delivery of public health care in the United States has resulted in the need for large health care organizations to be operated by professionally trained managers. In order for the managers to be sure of receiving valid and correct information for control an independent auditing system

should be established. The scope of the internal auditing department covers not only accounting and financial records, but the reliability of information and reports developed within the organization, the quality of staff performance, the extent to which company assets are accounted for and the extent to which current procedures and policies are carried out. The methods of conducting an audit are outlined. Audit reports should meet five criteria: (i) accuracy in facts and perspective; (ii) clear and logical presentation; (iii) brevity; (iv) punctuality; and (v) objectivity. The benefits of an internal audit are discussed. The need for more effective management within hospitals has resulted in the need for an instrument that can be used in any part of the hospital; the internal audit unit is expected to strive constantly to improve the hospital's health care delivery for the benefit of all concerned.

SUPPLIES AND STORES

SUPPLIES

1141. CARR, R. and SANGSTER, J. A. **Equipping health service buildings.** *Hospital and Health Services Review*, London, 1977, May, vol. 73, no. 5, pp. 154-157.

Health service activities are dependent upon the availability of equipment and an orderly approach in the early planning stages is essential in order to avoid difficulties in fitting the equipment to the space available. The impact of equipment on planning and designing is classified into four categories. Those categories serve not only as a cost control guide but indicate to architects and engineers the equipment for which provision must be made in the design. The design stages are outlined. Published information available to equipment officers and possible information sources are discussed. The five main steps in the process of equipping are: (i) preliminary consultation; (ii) specifying and scheduling; (iii) consolidation of schedules, final selection; (iv) ordering and receiving; and (v) storage and distribution. The use of computer facilities activity data, and cost guidance is discussed. The principles of buffering should apply to all moveable equipment to prevent damage to health buildings. The role of the supplies function in the development of a health service building project is: (i) a general contribution to planning and design; (ii) a reconciliation between established and future supplies policies and organization; (iii) the procurement of capital equipment, and (iv) the control of acceptable equipment costs.

1142. ZSUZSANNA, G. A kórházak közötti együttmüködés lehetöségei, 1. **[Possible co-operation among hospitals: 1.]** *Egészségügyi Gazdasägi Szemle*, Budapest, 1977, March, vol. 15, no. 1, pp. 93-97.

The management efficiency of hospitals could be improved if more institutes—perhaps those administered by the same local authority—followed a common purchasing policy by ordering directly from the manufacturing works, resulting in the acquisition of goods of higher quality at lower prices. The number of beds in hospitals administered by the Council of Budapest is approximately 15,000 and this volume makes possible the production of larger quantities, e.g. of tableware.

1143. SJUKVÅRDENS OCH SOCIALVÅRDENS PLANERINGS- OCH RATIONALISERINGSINSTITUT. Försörjningsverksamheten i Kronobergs läns landsting. **[Supply**

services provided by the Kronoberg County Council.] (Spri rapport 13/76) Stockholm, Spri, 1976, 120pp.

The supply services provided by the Kronoberg County Council, Sweden, during 1973 are described. The report deals with the following functions: catering; cleaning; clothing and linen supply; general supplies; general engineering; portering and internal and external transport; ambulances; pharmaceutical services; sterile supply; and clinical engineering. The report outlines the background, goal and organisation of Spri projekt 6048. The philosophy is discussed and the total resources, production and costs of all the supply services described. Recommendations arising from the project include: a need to improve the method of dealing with supply matters both on the directive (political) level and on the operative levels in the areas of development planning and operation; and central resources should be tapped for planning and financing studies aimed at developing an efficient management and work organisation for the supply apparatus.

1144. KOWALSKI, J. **Comprehensive materials management.** *Hospital Progress*, St. Louis, 1977, March, vol. 58, no. 3, pp. 76-83.

The director of materials management in an American hospital describes a comprehensive programme which is concerned with all supply functions: purchasing, printing, material delivery, storage and distribution, some elements of financial control (inventory control and patient supply charges), and centralized processing (laundry, sterilization, reprocessing of used materials). He shows that a programme of this nature can achieve substantial savings, particularly when a centralized delivery and storage system is operated. Innovations include the use of a daily exchange trolley system for linen and supplies; this saves storage space in departments and also saves nurses' time, since items are unpacked and ready for use when put on the trolley. There is also a surgical case trolley system: 95 per cent of the supplies and instruments needed for a given surgical procedure are assembled by central staff and sent to surgery; after use the trolley is returned to the central store, the supplies are sorted and, where appropriate, reprocessed; the trolley is sterilized and re-loaded.

STORES

See Abstract No. 1159

CATERING, DIETETICS, KITCHENS

HOSPITAL CATERING

1145. KOOGLER, G. H. and NICHOLANCO, S. **Analysis of a decision framework for prepared food systems.** *Hospitals*, Chicago, 1977, Feb. 16, vol. 51, no. 4, pp. 95-98.

Failure to evaluate all realistic alternatives needlessly increases the likelihood of problems when a prepared food system is implemented. The major decision alternatives that must be evaluated when contemplating a prepared food system are: menu style (hotel-restaurant versus cycle); make or buy (ready foods versus convenience foods); packaging (preplate versus bulk); inventory (chilled versus frozen); and reheating (centralized versus decentralized). A framework is suggested for evaluating and making

these decisions. An attempt is made to underscore the importance of making basic procedural and conceptual decisions related to prepared food systems before deciding the subcomponents of each area. Perhaps the most important element of the decision-making process is a thorough understanding of the interrelationships between each of the five major decision areas. This understanding, when it is combined with the suggested decision framework, should contribute to a well-planned, smoothly operating prepared food system.

1146. THOMAS, M. and others. **Hospital outbreak of Clostridium perfingens food-poisoning.** *Lancet*, London, 1977, May 14, vol. i, pp. 1046-1048.

An outbreak of *Clostridium perfingens* (*C. welchii*) food-poisoning affected one third of the patients (379) in a large hospital, and one patient died. The only common factor was a 'minced diet' served in the 19 affected wards. Within the affected wards the attack rate was 78 per cent among those having the minced diet and 42 per cent among those nominally having other diets. The cooking and storage of a minced-ham dish was found to be at fault: cuts of meat were too large, they were kept at room temperature for too long before refrigeration and after cooking they were put through mincers also used for raw meat. Final reheating was inadequate to destroy even vegetative bacteria and multiplication may have occurred during slow distribution to the wards. Outbreaks of *C. perfingens* food-poisoning are common in hospitals and some underlying problems are discussed. A plea is made for the Food Hygiene Regulations to apply to National Health Service premises and for simple but effective reforms in institutional catering management.

DIETETICS IN THE HOSPITAL

1147. DAVIS, P. B. and ELLIOTT, T. B. **Using supportive personnel to improve patient care.** *Hospitals*, Chicago, 1977, Jan. 1, vol. 51, no. 1, pp. 62, 64.

University Hospital, Boston, is one of three institutions that comprise the Boston University Medical Center. The hospital dietary department meets all the catering needs of the hospital including in-patient feeds, canteen services and special diets. A review of the department revealed three main areas of concern: departmental supervision was not uniform; there was a lack of communication between the patient and the dietary department; and there was a poor career structure for staff. The methods taken to improve patient service and dietary productions are discussed. The introduction of diet-technicans to the department, as middle management supervisors with direct contacts with diet-aides and patients in the wards has resulted in improvements in hospital service through better communication. A training scheme has provided greater mobility and an improved career structure for staff.

LAUNDRIES AND LINEN SERVICE

LAUNDRIES

1148. DAMERGER, A. Die Wäscherei im Rahmen der Krankenhaus-Hygiene. **[The laundry in the setting of hospital hygiene.]** *Österreichische Krankenhaus-Zeitung*, Wien, 1977, Feb., vol. 18, no. 2, pp. 111-118, 121-122.

The replacement of small hospital laundries by central or commercial laundries is

under way in Austria and it is only a matter of time before this policy becomes standard practice. The special requirements from the point of view of hygiene which are essential for hospital laundry are set out and guidelines for laundering hospital linen in laundries outside the hospital are laid down. These guidelines cover: buildings and machines; laundry technique and hygiene; laundry procedures; transport; assurance of supply; and general conditions of contract. The main factors involved in laundry hygiene are as follows: disinfection of all textiles; incorporation of a long-term disinfectant in the laundry and cleaning programme; separation of clean and dirty areas; disinfection of transport vehicles and equipment; hygienic conditions for, and surveillance of, staff; and a suitable system for transporting soiled linen.

1149. CHILARD, C. La blanchisserie centrale du centre hospitalier regional de Brest. **[A centralized laundry system in the regional hospital centre of Brest.]** *Gestions Hospitalières*, Mantes, 1977, Jan., no. 162, pp. 73-76.

The new laundry building has a total area of 3,500 m^2 and can deal with eight metric tons of laundry per day. Solid material is sorted initially into eight categories in each ward or department and placed in sealed paper sacks which are loaded onto trolleys of eight different colours. It is collected by lorry each day both from the regional hospital itself and from smaller establishments in the region. When it reaches the laundry it is weighed and disinfected. Large items are washed in a tunnel which has automatic feed, and spin, and a capacity of 800 kg/hour; smaller items—which account for 50 per cent of the total—are washed in one of five washing-spindrying machines which discharge their finished loads onto a conveyor belt for automatic ironing. There are five photographs, one of the exterior and four of the interior of the new laundry.

HOSPITAL LINEN AND TEXTILES

1150. SMITH, V. M. **Seafield warm air contact mattress: the development of a hot air mattress to prevent hypothermia during neontal anaesthesia and surgery.** *Nursing Times*, London, 1977, March 10, vol. 73, no. 10, ABPN supplement, pp. 3-5.

A portable warm air contact mattress, consisting of a mattress unit, a billow cover, a power unit, and an air tube incorporating a temperature probe, has been devised for use during surgery in babies. The system operates effectively over an ambient temperature range of 15-30°C and provides a contact temperature of 37.5°C. During clinical assessment trials the device was found to be completely reliable, quiet, and surgically acceptable. Provided the baby is in the supine position on the mattress, core temperature can be increased and maintained at will by using the heater control. The mode of operation of the apparatus is described and there are three photographs and two tables which give details of eight babies during surgery with whom the apparatus was employed.

1151. **Hospitals considering less than daily bed changes.** *Hospitals*, Chicago, 1977, Feb. 16, vol. 51, no. 4, pp. 107-109.

One of the hospital practices that has tended to become ritualized is the daily bed change. But the need for it is beginning to be questioned in the light of modern health

care practices. There have been tremendous advances in the areas of antisepsis and asepsis, medical technology, drugs and medical practice. The average length of stay has been reduced from 14 days in 1934 to 7.7 days in 1975 and today's patients are more ambulatory. In a survey of 40 hospitals in the Philadelphia area, 11 were changing beds six days a week or less. In these hospitals considerable financial savings have resulted. Before an every-other-day bed change programme was implemented in one hospital, extensive interviews were conducted with the administration, medical and nursing staff, and patients and their families. Criteria were established by the nursing department for determining whether or not an extra bed change was needed. A 90-day trial programme met with some initial criticism, but the programme ran so smoothly that the administration decided to implement it throughout the hospital.

HYGIENE IN THE HOSPITAL

HOSPITAL INFECTIONS

See also Abstract No. 1146

1152. CHAVIGNY, K. H. **Microbial infections in hospitals: a review of the literature and some suggestions for nursing research.** *International Journal of Nursing Studies*, Oxford, 1977, vol. 14, no. 1, pp. 37-47.

This paper reviews the literature on hospital epidemiology in order to define the present problems in hospital-acquired infections and other communicable diseases and formulates generalized hypotheses which accentuate areas requiring research in nursing. Two main categories of infection are discussed: hospital-associated or 'incidental' infections which develop from contact within the hospital; and iatrotechnical infections, which would not have occurred unless the hospitalization process had provoked them through treatment, procedures, or exposure to indigenous pathogeneticity. Hospital infections are further divided into exogenous, acquired from sources outside the patient, and endogenous, which are a result of host factors only. This dichotomy accentuates the responsibility of the nursing profession to provide and maintain a safe environment for patients in health care facilities. Examples of hypotheses for future research are listed. Sixty-one references to the literature, largely from the United States, are included.

1153. DANIEL, S. O. **An epidemiological study of nosocomial infections at the Lagos University Teaching Hospital.** *Community Health*, London, 1977, Jan., vol. 8, no. 3, pp. 139-144.

During the period January 1974 to June 1975 there were 1,081 hospital infections in 932 patients at Lagos University Teaching Hospital, an infection rate of 7.5 per cent. The mean age of the patients was 37 years and there was no appreciable sex difference in infection rates. Of the 1,081 reported infections, 42 per cent came from surgery, 20 per cent from paediatric, 18 per cent from medical and 20 per cent from maternity wards. Surgical wounds were the most frequently reported site of infection (35 per cent), followed by urinary tract 28 per cent and cutaneous lesions nine per cent. *Escherichia coli* accounted for 23 per cent of all isolates, *Klebsiella* for 19.3 per cent and *Staphylococcus aureus* for 19.1 per cent. Compared with developed countries, these infection rates

seem rather high. Suggestions from improvement such as more effective infection surveillance and reporting are proposed. A plea is made for continuous vigorous epidemiological research on hospital infections not only in the University Teaching Hospital, but also in all other hospitals in Lagos and Nigeria.

1154. O'FARRELL, S. M. and others. **Escherichia coli in a maternity ward.** *Infection*, München, W. Germany, 1976, vol. 4, no. 3, pp. 146-152.

This study examines the relationship of environmental strains of *Escherichia coli* to those in new born babies. Over a 14 day period, 58 faecal and nasal swabs from all 23 babies in a neo-natal ward, 244 from the hands and clothing of staff, and 425 samples of ward air were examined for *Escherichia coli*. None of the 58 nasal swabs showed *E. coli*, but 49 faecal swabs, 48 hand or clothing swabs and 153 air samples were positive. The results, given in eight tables and diagrams, demonstrated that there is a great variety of *E. coli* serotypes present in a normal nursery for neonates. Their presence on the nurses and in the air was related to the admission and discharge of the affected babies.

SOURCES OF INFECTION

See also Abstract No. 1154

1155. SMITH, P. W. and MASSANARI, M. **Room humidifiers as the source of Acinetobacter infections.** *Journal of the American Medical Association*, Chicago, 1977, Feb. 21, vol. 237, no. 8, pp. 795-797.

During a four-month period at University of Iowa Hospital, Iowa City, 24 patients contracted systemic infections with *Acinetobacter calcoaceticus*; the outbreak primarily involved two medical wards. Environmental investigation implicated unheated room humidifiers at the patients' bedsides as the source of infection in six of the patients. After the humidifiers were removed from the medical wards, there were no more cases of *Acinetobacter* bacteraemia on those wards. Two new cases were found on non-medical wards where the humidifiers were still in use. Decontamination of humidifiers has been very difficult to achieve and serious consideration should be given to the abandonment of these devices.

1156. EICHHORN, J. H. and others. **Contamination of medical gas and water pipelines in a new hospital building.** *Anesthesiology*, Philadelphia, 1977, April, vol. 46, no. 4, pp. 286-289.

A new eight-storey 176-bed addition to Beth Israel Hospital, Boston, Mass., was opened in 1976. During routine testing for cross-connections and purity of oxygen delivered to the first completed patient-care floor, contamination was discovered in the form of odour from the medical gas outlets and a fine grey dust. This consisted of a volatile hydrocarbon at an initial concentration of 10 parts per million and a dust of particulate matter. In water from new taps bacterial contamination with as many as 400,000 organisms per 100 ml. was present. Studies were carried out to discover the nature and origin of the contamination. Purging the pipeline systems with continuous flows proved effective in reducing contamination. The persistance of a low level of the hydrocarbon suggested that there was a continuous input of contamination into the

system from the hospital's compressor unit. The local atmosphere was the likely source of contamination. Planners, builders and medical staff should all be aware of the potential for such hazards in a new hospital building.

PREVENTION AND CONTROL

See also Abstract Nos. 1152, 1155, 1194

1157. IWARSON, S. and others. **Hepatitis B immune globulin in prevention of hepatitis B among hospital staff members.** *Journal of Infectious Diseases*, Chicago, 1977, March, vol. 135, no. 3, pp. 473-477.

In a double-blind trial of hospital staff at the haemodialysis centre, Sahlgren's Hospital, Göteborg, Sweden, who were at risk of contacting hepatitis B, 110 subjects recovered prophylactic injections of hepatitis B immune globulin (HBIG) or immune serum globulin (ISG). An additional 125 members of staff received no prophylaxis and served as a control group. During the study period of 28 months, 13 cases of clinical hepatitis B occurred in the untreated group, whereas only three cases occurred among those who received prophylaxis. The present study indicates that ISG with a reasonably higher titer of anti-HBs (1:100) if given prophylactically might be effective in reducing the incidence of hepatitis B among hospital staff. HGIG with a high titer of anti-HBs (1:355,000 by PHA) is revealed to be more effective than no prophylaxis in reducing the incidence of clinical hepatitis B infection among hospital staff in high-risk units. However additional studies are required to determine whether ISG is as effective as HBIG in reducing the incidence of hepatitis B when used prophylactically.

1158. AMERICAN COLLEGE OF SURGEONS. COMMITTEE ON CONTROL OF SURGICAL INFECTIONS. **Manual on control of infection in surgical patients** (Chairman: W. A. Altemeir) Philadelphia, Lippincott, 1976, xxxiii, 280pp. £12.80

The proceedings of four symposia on the control of surgical infections held between March 1970 and November 1972, are presented. Each symposium concentrated upon selected areas of surgical infections. The contributions to the symposiums cover such aspects as: incidence and the cost of infection; definition and classifications of surgical infections; epidemiology and surveillance of infection; biology of infection; pre-operative preparation of the patient; preparation of the operating team and supporting staff; preparation and maintenance of a safe operating room environment; influence of operating techniques on the rate of infection; in-hospital infections other than surgical wound infections; use and abuse of antibiotics; hospital design requirements for safe surgery; isolation for infection control in surgical patients; housekeeping techniques; laboratory support; and sterilization. Selected references are given after each paper.

HYGIENE IN THE OPERATING THEATRE

See Abstract No. 1160

STERILIZATION

1159. GLADDING, G. D. and BALLEW, T. D. **Proper stock rotation is colored with a positive marking.** *Hospitals*, Chicago, 1977, March 16, vol. 51, no. 6, pp. 154, 156.

The Clinical Center at the National Institutes of Health (NIH), Bethesda, Md., is a

500-bed government research hospital. The central supply service is administered by the pharmacy department and stocked with approximately 2,600 different items requested by 59 patient care areas in the Clinical Center. A system that uses colour-coded autoclave tape on surgical packs for surgical nursing service was developed in order to maintain proper stock rotation and an accurate check for outdated sterile supplies. The new system requires that staff from the central sterile supply service check for out of date sterile packs on the 1st and 15th of every month instead of on a daily basis as had been the case with the previous system. By knowing which colour of tape was wrapped round sterile packs six to eight weeks before the date of the check staff can now rapidly see the out of date packs. The out of date packs are returned to the central sterile supply service for reprocessing. A control number is also fixed to the packs to indicate the date the packs were sterilized, the sterilizer used and the operator. A work-flow pattern has been developed and requests for duplicated supplies that were not needed have become non-existent. The colour coded system has been expanded to all areas of packaging within the central sterile supply service.

AIR HYGIENE

See also Abstract No. 1155

1160. Luchtvervuiling in operatiekamers: gasevacuatie-systeem uit Nederland trekt internationaal de aandacht: preventieve maatregelen tegen beroepsziekte in O.K. **[Air pollution in the operating theatre; a Dutch gas-expulsion system attracts international attention: preventive measures against occupational diseases in the operating theatre.]** *Technische gids voor Ziekenhuis en Instelling*, Amsterdam, 1977, March 21, vol. 46, no. 1120, pp. 120-121.

Though occupational disease among theatre staff through inhalation of anaesthetic gases breathed out by patients has not been scientifically proven, research into preventive measures has been carried out internationally. What is required is a fail-safe system, easy to use, at low cost and efficient. In 1975 a team of Dutch technicians developed a gas expulsion system whereby sources of contamination, such as outlets from patients' breathing apparatus, are fitted with a collecting device. Exhaled gases pass via the discharge opening of the expiration valve along light-weight concertina tubing into a rubber collection bag inside a flask filled with room air. Diluted with this air the gases then pass through an outlet via tube into the central discharge system and into the open air. Optimal attention is paid to safety aspects such as a sudden increase of pressure in the discharge route (coughing), negative pressure, vacuum capacity, flexibility of the rubber bag, easy methods of attachment, few regulation knobs. A detailed technical description is given including two drawings. The system is now being used in many hospitals in the Netherlands.

SAFETY MEASURES

FIRES AND FIRE PREVENTION

1161. Cox, R. L. F. **Emergency evacuation of patients in hospital.** *Fire*, Tunbridge Wells, 1977, May, vol. 69, no. 863, pp. 625-627.

There are a large number of factors which need to be taken into consideration in

the evacuation of patients. The need for guidance in a fire situation from somebody with knowledge of what to do is essential, since all too frequently the start of the evacuation may be commenced by junior staff with very little knowledge of the correct procedures. Patients in intensive care units or operating theatres are particularly vulnerable and each of these areas needs to be protected with a one-hour fire resisting structure all-round, but with a bolt hole through which they can be removed if all else fails. The width of emergency exits is discussed. Methods of evacuation fall into two categories: emergency and precautionary. The only way to clear patients in the limited time available in an emergency is to drag them along the floor on bed covers. Aids for use in precautionary evacuation include cords, mattresses and mattress straps, harnesses and wheelchairs. Methods of carrying patients by nurses are discussed. The most effective evacuation methods for nurses to use are: the blanket drag; by mattress; by chair; or by various methods taught in nursing school. The basic needs for the protection of patients are: (i) the entrance to the ward and the ward itself should be protected by a fire resisting structure with an alternative method of exit; and (ii) the means to summon assistance and the local fire brigade by the operation of a breakglass wall point, and fire extinguishers at both ends of the ward together with a box of mattress straps.

PLANNING FOR MASS EMERGENCIES

1162. HOWARD, J., editor. **Developments in disaster management: proceedings of the Action for Disaster International Conference held at Govan Town Hall, Glasgow on 13-14 April 1976.** Glasgow, Action for Disaster, 1976, [vi], 95pp. £3.50

The proceedings of the Action for Disaster International Conference held in Glasgow, April 1976, considering developments in disaster management are presented. Subjects covered by the papers include: police emergency procedures, fire and rescue experience, ambulance response; medical response in hospitals; off-shore disasters; development of communication systems; the deaf, disabled and elderly in disasters; the Moorgate tube disaster; the Flixborough explosion; identification of hazardous freight; and rescue services in Switzerland, West Germany and France.

1163. HOYLE, J. D. **Tornadoes! Prepare for the unpredictable.** *Hospitals*, Chicago, 1977, Feb. 16, vol. 51, no. 4, pp. 71-73.

In the past three decades, tornado frequency in the United States has increased from a national low of 155 per year to a current national average of more than 800 per year; mean path length and intensity have also increased. Because of rapid onset of tornadoes, a hospital must formulate and practice warning and preparedness plans to protect its patients, staff and visitors. Warning systems include national weather radio system, local emergency service networks, sirens and commercial radio. The experience of a tornado passing within view convinced St. Luke Hospital, Fort Thomas, Ky., of the need to develop a preparedness and protection plan, brief details of which are given. The hospital's architects analysed the entire structure and provided detailed floor plans (an example is reproduced) showing the best areas on each floor for use as shelter areas because of their structural integrity. The hospital also adopted a damage control procedure that can also be used in the event of fire or internal disaster.

THE PATIENT

ADMISSION AND RECEPTION

1164. LORRANG, F. L'informatique en temps réel aux admissions. **[On-line data processing for admissions.]** *Gestions Hospitalières*, Mantes, 1977, Jan., no. 162, pp. 41-45.

The system of on-line data processing of data relating to patient admissions now in use in Metz Hospital is described. The data are fed into a T1600 Télémécanique computer either in conversational mode or using a Hewlett-Packard optical scanner. They are stored on both disc and magnetic tape and can be retrieved on a screen, on print-outs, on punched cards, or on punched tape. A bit file is prepared when a patient is admitted and programmes for accounts, treatment, and bed movements initiated. Records are available more quickly than in the past and the nursing staff spend less time on administration. The description includes a diagram of the general organization of the system, a list of the programmes used, and a list of the 15 documents and statements produced by the computer.

WELFARE OF THE PATIENT

See also Abstract Nos. 1079, 1170, 1190, 1195, 1196, 1198, 1216

1165. MAYERSON, E. W. **Putting the ill at ease.** Hagerstown, Md. & London, Harper & Row, 1976, xviii, 313pp. £7.45

This book considers all communication between the patient and the doctor as therapeutic. The first five chapters cover aspects of clinical interaction including: taking the patient's medical history; making an informed decision; genetic and environmental counselling; patient education and instructions for self-care. The last six chapters consider specialized situations, including communication with infants and children; the elderly; the terminally ill; the drug and alcohol dependent patient; the casualty department, and the patient and his family. There is a bibliography on pages 295-299.

1166. **Pre-operative assessment unit takes fear out of patient care.** *Hospital Administration in Canada*, Don Mills, Ont., 1977, March, vol. 19, no. 3, pp. S14-S15.

An account of experience in the special admission unit for elective surgery cases at Halifax Infirmary Hospital. Patients arrive only one day before their operation and receive individual care which is planned beforehand and given without delay. They are encouraged to talk about their fears and are given explanations and guidance. As a result they are less frightened pre-operatively and more co-operative after surgery.

1167. CLARK, S. **Newest engineering problem—specify silence.** *Hospital Administration in Canada*, Don Mills, Ont., 1977, March, vol. 19, no. 3, pp. 64-65.

There is increased awareness of the need to protect the hospital environment from noise pollution, and the author profers practical advice to the hospital engineer on how to recognise unacceptable noise levels in new equipment before it is purchased,

and how to persuade manufacturers to produce equipment with acceptable noise levels. He recommends the purchase of a sound level meter or a combined vibration analyser and sound level meter, and explains the decibel scale in simple terms.

1168. KINNEY, M. R. **Effects of preoperative teaching upon patients with differing modes of response to threatening stimuli.** *International Journal of Nursing Studies*, Oxford, 1977, vol. 14, no. 1, pp. 49-59.

A review of the literature demonstrated an awareness of the need for individual preparation for surgery. The focus has been on the value of anxiety in the preoperative period and the consequences of its presence or absence in the postoperative period. No studies have been reported which attempt to identify some useful way for distinguishing between individual differences in regard to what kind of information patients need or can actually use. In the study reported here male patients for open-heart surgery were asked to complete the Repression-Sensitization Scale on admission at least two days prior to surgery during which time baseline measurements of autonomic stimulation were measured. The afternoon before surgery, they were asked to complete the State-Trait Anxiety Inventory Form before and after a teaching period. Blood pressure and heart rate were determined one and four hours after teaching, and blood samples were taken one, two and four hours after the teaching period. Patients were classified as repressors, sensitizers or neutrals. The results indicated that each group, although differing in typical mode of response to threat, experienced some decrease in anxiety level following pre-operative teaching. The need for further investigation is stressed.

HOSPITAL SOCIAL WORK

1169. AMERICAN HOSPITAL ASSOCIATION. **Development of professional standards review for hospital social work.** Chicago, American Hospital Association, 1977, viii, 52pp. $7.00

The effect of current legislation in the United States which focuses on helping medical and nursing staff to develop systems of evaluation and quality control is discussed. The goals related to the implementation of the Professional Standards Review Organizations are outlined together with the effects of utilization review, documentation, peer review and audits upon standards of hospital social work. The minimal structural standards for the Professional Standards Review are presented with various recommendations arising from the study.

THE GENERAL PRACTITIONER AND HIS PATIENTS

See Abstract No. 1165

TRANSPORT OF PATIENTS

See Abstract No. 1193

HOSPITAL CARE

See also Abstract Nos. 1109, 1110, 1127, 1140, 1147, 1166, 1169, 1188, 1201-1203, 1205, 1216

1170. WILKES, E. **Help for dying patients and their relatives.** *Mims Magazine*, London, 1977, April, no. 40, pp. 37-39, 41, 44, 47-48.

The author offers practical advice to the general practitioner on the management of terminal illness, and in particular on the management of cancer patients being treated at home. More patients now desire a frank discussion of their situation and the doctor must endeavour to establish mutual confidence and trust. He must organize and support the relatives and at the outset discuss with them the whole problem of terminal care. Ways and means of maintaining patient morale are suggested and the control of symptoms in various types of cancer is discussed in considerable detail. Advice is also given on the control of pain, breathlessness, and confusion, and finally, on the control of the noisy breathing which could be distressing for the watching relatives as death approaches.

1171. PHANEUF, M. C. **The nursing audit: self regulation in nursing practice. 2nd edition** New York, Appleton-Century-Crofts, 1976, xix, 204pp. £6.85

The second edition of this book deals with the entire process of patient care evaluation, and shows how basic evaluation processes can be used for assessing the quality of nursing care. Aspects covered include: quality appraisal; planning and the use of nursing audits; and the effect nursing audit has upon care.

1172. TESCHER, B. E. and COLAVECCHIO, R. **Definition of a standard for clinical nursing practice.** *Journal of Nursing Administration*, Wakefield, Mass., 1977, March, vol. 7, no. 3, pp. 32-44.

The authors briefly introduce specific job descriptions which have been developed at the University of California for four levels of clinical nurse from Clinical Nurse I, the newly registered nurse, to Clinical Nurse IV who must have a baccalaureate degree in nursing with six years' recent clinical experience in an area of specialization and, preferably, a master's degree. The job descriptions are reproduced here in full: they are behaviour-oriented and classify behaviour into nursing process (assessment, planning, implementation, and evaluation), teaching, communication, evaluation, and (for Clinical Nurse II-IV) research.

1173. AVERILL, R. F. and MCMAHON, L. F. **A cost benefit analysis of continued stay certification.** *Medical Care*, Philadelphia, 1977, Feb., vol. 15, no. 2, pp. 158-173.

A large portion of the resources of the Professional Standards Review organization programme have been directed towards the review of in-patients to determine the need for continued in-patient care. The primary goal of this review process is the containment of hospital costs through the elimination of unnecessary in-patient care. A cost benefit analysis of this review process shows that the potential financial savings are unlikely to offset the costs associated with the review process.

1174. BERRY, N. J. **PSRO impact on utilization: forecast in a cloudy crystal ball.** *Hospitals*, Chicago, 1977, Feb. 16, vol. 51, no. 4, pp. 57-60.

This paper reviews certain provisions of the legislation on professional standards

review organizations (PSROs), available data and various theories, in order to examine the programme's potential impact on future acute and long-stay care needs. Number of admissions, length of stay and available alternate services are primary factors in the determination of bed needs. In turn, they are affected by changes in and interactions between technology, physician's practice patterns, financing mechanisms and consumer attitudes. Without data on the effect of PSROs on each of these factors, it is, at best, difficult to choose among the viewpoints presented. Therefore, although PSROs should be recognized as having a potentially significant influence on demand for and use of acute and long-stay care services, their impact cannot yet be quantified validly. A mechanism for measuring the impact of PSROs should be developed and implemented as soon as possible in order to provide sufficient data with which to update and revise projections of demand for facilities.

1175. BERKI, S. E. and others. **Enrollment choice in a multi-HMO setting: the roles of health risk, financial vulnerability, and access to care.** *Medical Care*, Philadelphia, 1977, Feb., vol. 15, no. 2, pp. 95-114.

The potential success of health maintenance organizations (HMO) depends on their ability to build on adequate membership. This paper reports a study of the enrolment decisions of an employed and a self-paying population. The choice involved one open- and two closed-panel health maintenance organization-type plans as well as Blue Cross/Blue Shield. The results show that there is no adverse health risk in self-selection. Those who enrol in any HMO-type plan are younger and have younger and larger families and lower per capita income than those who do not. No meaningful differences in terms of health status, health concern or prior use are found. Of the few differences found between those who enrol in closed- and open-panel HMO-type plans, the most significant was that those with an established physician tended to follow him into the open-panel plan. Premium differences did not affect the results, since premiums were being paid by employers; rather the validity of the results in terms of non-financial factors is enhanced by the removal of cost considerations.

1176. SALKEVER, D. S. and others. **Episodes of illness and access to care in the inner city: a comparison of HMO and non-HMO populations.** *Health Services Research*, Chicago, 1976, vol. 11, no. 3, pp. 252-270.

Using data from a 1974 household survey, accessibility to ambulatory care is compared for residents of the area around Johns Hopkins Hospital whose usual source of care is a health maintenance organization (HMO) (the East Baltimore Medical Plan) and residents of the same area with other usual sources of care. Accessibility is measured by the probability of receiving care for an episode of illness. Results from multivariate linear and profit regressions indicate that children using the HMO are more likely to receive care than are children with other usual care sources. No significant differences in the probability of receiving care are found among adults. Evidence of a substitution of telephone care for in-person care is also found among persons using the HMO. Data from a 1971 household survey of the same area suggest that selectivity is not an important confounding factor in the analysis.

HOME CARE, AFTER-CARE

See Abstract Nos. 1069, 1191, 1197, 1217

SPECIAL DEPARTMENTS

ADMISSION UNITS

1177. FLECK, H. Analyse der Ablauforganisation in einem medizinischen Untersuchungszentrum mit Hilfe der Netzwerktechnik. **[Analysis of the sequence of operations in a medical examination centre with the aid of network technique.]** *Methods of Information in Medicine*, Stuttgart, 1977, April, vol. 16, no. 2, pp. 81-88.

The PERT (Programme Estimation Review Technique) critical path system, as used for analysing medical examination procedures in a pilot study at the West German Air Force Medical Institute, is described. The study is one of the subjects being investigated in connection with the planning of an electronic data processing system for the Institute. The paper includes reproductions of specimen printouts and shows the possible time-saving effects of the technique.

WARDS

See Abstract Nos. 1100, 1198

OPERATING SUITES

See also Abstract No. 1160

1178. TROUTEN, A. F. **The operating room door is open.** *Hospital Administration in Canada*, Don Mills, Ont., 1977, March, vol. 19, no. 3, pp. S9, S11.

The theatre nurse requires particular knowledge and skills for the care of patients undergoing surgery but she also needs to communicate with a whole series of nursing specialists, to keep abreast of new developments in her own field, to share her experience with the trainees under her care, to be involved in professional associations and participate in the planning for and maintenance of high standards of care. If in the past there have been barriers between theatre nurses and other hospital staff, this is no longer the case.

ANAESTHESIA

See Abstract Nos. 1110, 1160

PHARMACY

1179. STIMMEL, G. L. **Clinical pharmacy services in mental health facilities.** *Hospitals*, Chicago, 1977, Jan. 1, vol. 51, no. 1, pp. 71-74.

Pharmacy practitioners in psychiatric institutions have greatly expanded their role in contributing to rational and safe drug therapy during the past six years in the United States. Factors that have contributed to the increased need for pharmacists' participation include: the development of identical pharmacy services on a geographical basis; the increasing number of facilities with limited budgets; the importance of maintaining the patient in the community; and the need for an available source of

drug information. The primary area of responsibility for the pharmacist is drug therapy monitoring. Other roles include drug consultation, drug counselling and drug distribution. Examples of implementation modes are outlined. Many pharmacists already possess the skills necessary for providing clinical services, and these skills indicate the development of a new role of clinical menta! health pharmacy practice.

1180. APPLEWHITE, K. and others. **Dispensing for individual inpatients.** *Nursing Mirror*, Sutton, 1977, April 28, vol. 144, no. 17, p. 62.

The experiences of nursing and pharmaceutical staff with individual dispensing services for in-patients on geriatric, surgical and medical wards in hospitals in Salford Area Health Authority (Teaching) are discussed. The Ross system was introduced on a trial basis on a geriatric ward at Ladywell Hospital, Salford. The advantages of this system were: (i) ease of identification of patient's drugs; (ii) individual attention is given to each patient's prescription by nursing staff; (iii) nursing time is reduced; (iv) drug stock is reduced; and (v) there is greater contact between pharmacy and nursing staff. The system was further evaluated in two surgical wards and two medical wards of an acute hospital (Salford Royal Hospital) using the 'Hackney' trolley. The advantages and disadvantages of the scheme are discussed. The evidence suggests that individual dispensing for hospital in-patients in geriatric and medical wards is a safe and efficient method of drug distribution which can result in a reduction in drug expenditure. The system was not well received on the two surgical wards but it is considered that a further trial using the 'Bristol Maid' trolley would be worthwhile.

LABORATORIES

1181. RINSLER, M. G. **Making do: efficiency in the National Health Service. Chemical-pathology services.** *Lancet*, London, 1977, April 30, vol. 1, pp. 946-947.

The demands on a chemical-pathology service can be defined in various ways including needs of patients in their geographical environment, needs of groups categorised in terms of their hospitals, and their diseases, and the needs as seen by the physician or surgeon in charge of the patients. The resources deployed to provide a laboratory service are: space, skilled staff and the specialized apparatus. The current situation in the National Health Service is that services have been centralized in larger and larger laboratories. A case has been made for the multispecialist chemical-pathology laboratory and the general department in smaller hospitals in view of the recent emphasis on the community hospitals. The problems of supervision, interpretation of data and staffing are considered once the possibility of a decentralized service is acknowledged. Chemical-pathology services provided in West Germany, the United States and Canada are discussed. A less rigid approach to handling problems in the National Health Service could provide a superior service at less cost.

BLOOD TRANSFUSION DEPARTMENT

1182. PEGELS, C. C. and others. **An analysis of selected blood service policy changes.** *Medical Care*, Philadelphia, 1977, Feb., vol. 15, no. 2, pp. 147-157.

The principal national goals for a blood transfusion system are concerned with

shortage, quality, accessibility and efficiency. Since the operating objectives of a regional blood service based on these goals are in partial conflict, a single policy does not exist. Using a computer-based planning system, four policies are examined and tested for their effects on these objectives. The policies are: use of frozen red cells (a technological alternative); extension of the useful life of fresh blood (a legal alternative); improved collection planning (a planning alternative); and improved inventory management (a management alternative). Model projections of the effects of each policy and comparative performance of each policy with respect to the principal objectives are discussed. The best solution is adoption of the following policies: (i) increasing the legal life of blood to 28 days; (ii) improve blood collection scheduling; and (iii) increase the use of the first-in first-out policy through improved management. Policy (i) requires government action, but policies (ii) and (iii) can be implemented by administrative decisions of regional blood managers.

1183. GOODSITE, L. M. and others. **A computer program to record technical data in leukapheresis and plateletpheresis procedures.** *American Journal of Clinical Pathology*, Philadelphia, 1977, March, vol. 67, no. 3, pp. 241-246.

A computer program for the recording of data and calculation of results from leukapheresis and plateletpheresis procedures has been developed. It provides individual print-outs of specific data for each pheresis, including some calculations and translations, an abbreviated data listing in order of date of pheresis, lists of donors, a deletion option which allows specific donor records to be deleted from the master file tape, and a statistical option which allows the data accumulated to be analysed periodically by statistical subprograms. The program can be adapted to most computers and this would facilitate the exchange of data among workers in this field. This description of the program includes a sample print-out of information from one leukapheresis procedure, a program flow chart, and a sample individual donor data card format.

DIAGNOSTIC X-RAY DEPARTMENT

1184. DAHAN, J. Économies . . . et radiologie. **[Economies . . . and radiology.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1977, March, vol. 32, no. 378, pp. 54-58, 63; summaries in English, German, Italian and Spanish, p. 63.

Economies in the radiology department can be achieved by doing without the protective photographic paper in which the films are kept, by mechanization of film packaging, standardization of sizes and quantities of film, more careful preparation of the developing baths, the use of magnetoscopy, phototimers, and of mixers for the automatic preparation of photographic solutions, and by more careful maintenance. The numbers of copies of films can be cut, old films can be sold for their metal content after five years, and, finally, the number of requests for X-rays should be reduced.

PHYSIOTHERAPY DEPARTMENT

See Abstract No. 1185

OCCUPATIONAL THERAPY DEPARTMENT

1185. EMPLOYMENT SERVICE AGENCY, CAREERS AND OCCUPATIONAL INFORMATION CENTRE, DEPARTMENT OF EMPLOYMENT, CAREERS SERVICES BRANCH and CENTRAL

OFFICE OF INFORMATION. **The remedial professions. 6th edition.** (Choice of careers 52) London, Her Majesty's Stationery Office, 1976, 40pp. £0.30

The term 'remedial professions' covers the three professions—occupational therapy, physiotherapy and remedial gymnastics. This career guide outlines the aims of each profession, treatment of the patients, training requirements and areas of work. Further prospects in the remedial professions are outlined. An appendix includes information on music therapy, art therapy, movement and drama in therapy, and play therapy.

1186. FERGUS, F. M. and BUCHANAN, K. **The use of activity groups as an integral part of O.T. in child psychiatry.** *British Journal of Occupational Therapy*, London, 1977, April, vol. 40, no. 4, pp. 82-83.

The Department of Child and Family Psychiatry at the Royal Hospital for Sick Children, Glasgow, has found that activity groups are of much value in the treatment of emotionally disturbed children. This paper discusses why activities are used in a group, the selection of activities, preparation of the groups and the aims of the groups.

DEPARTMENTS FOR SPECIAL THERAPY

See Abstract Nos. 1210, 1211

INTENSIVE CARE UNITS

1187. CARA, M. L'acharnement thérapeutique. **[Intensive care.]** *Gestions Hospitalières*, Mantes, 1977, Jan., no. 162, pp. 17-26.

The author uses eight case reports to illustrate one of the dilemmas faced by doctors when a patient requires resuscitation after a pre-operative mishap or an accident. He describes three types of case: those in whom resuscitation is attempted almost immediately and is nearly always successful; those in whom it is of no avail; and an intermediate type in whom resuscitation has been delayed for some minutes and where the final outcome is rarely good, although intensive care may last for weeks or months and cannot be withheld without the doctors being accused of negligence. He believes that the remedy does not lie in increasing the volume of emergency services; he suggests, rather, some simple measures: a separate budget for safety precautions in hospitals, the appointment of a doctor with responsibility for all the high risk areas in the hospital, the establishment of medical audit committees (entailing a modification of the Hippocratic oath), and compulsory undergraduate training in the treatment of emergencies.

SPECIAL HOSPITALS AND UNITS

OUT-PATIENT

See also Abstract No. 1176

1188. FREEBORN, D. K. and others. **Health status, socioeconomic status, and utilization of outpatient services for members of a prepaid group practice.** *Medical Care*, Philadelphia, 1977, Feb., vol. 15, no. 2, pp. 115-128.

When evaluating the effectiveness of medical care programmes, one concern is

whether receipt of care is based upon health care needs or upon socioeconomic status. This study describes the relation between health status and socioeconomic status and attempts to determine which has the greater effect on the use of ambulatory care. Data were derived from the medical records of a five per cent sample of the 200,000 members of a health maintenance organization. Social, economic, situational and attitudinal data were provided by 2,603 respondents in a household interview survey. Since a population's perceived health status may reflect health need, information from the survey provided measures of health status that ranged from specific symptoms and complaints to a general measure of perceived health status. Although the findings varied somewhat according to which variables were considered, they generally showed health status to correlate more highly than socioeconomic factors with the use of services. An exception was the use of preventive services, which was not significantly related to health status measures but rather, for women, to education and, to a lesser extent, income.

1189. HOWARD, R. S. **Clinic information system fills teaching, audit, managerial needs.** *Hospitals*, Chicago, 1977, March 16, vol. 51, no. 6, pp. 140, 142, 144.

The Family Practice Service, Madigan Army Medical Center, Tacoma, Washington, has developed an out-patient information system to monitor patient care, audit medical records and examine out-patient information for the purposes of research. The Family Practice Service provides out-patient care to approximately 12,000 patients with 3,500 visits per month. The information system is used to evaluate the quality of care and for conducting peer review and practice profiling. The code system the clinic uses, the International Classification of Health Problems in Primary Care (ICHPPC), is a 371-rubric coding system which allows the doctor to record what he considers to be the essential content of each doctor-patient encounter. It provides a coding system that is general in nature and manageable. The possible uses for the information include: long-term studies on ambulatory patient compliance with drug therapy, and justification of budget and manpower requests. The problems encountered by the system are outlined. The code itself is concise and timesaving and offers the user flexibility in modifying the system to meet his needs and capabilities.

1190. LAZES, P. M. **Health education project guides outpatients to active self-care.** *Hospitals*, Chicago, 1977, Feb. 16, vol. 51, no. 4, pp. 81-82, 84, 86.

In the waiting room of the out-patient clinic at Martland Hospital, Newark, N.J., a health education project has been established to disseminate preventive health information. Bilingual (Spanish and English) pamphlets, posters and videotapes provide patients with information they need, to assume responsible roles as health care consumers. Discussion groups and workshops are conducted each weekday between 0900 and 15.30. The objectives, development and staffing of the project are outlined. The staff of the health education project, who are provided by the College of Medicine and Dentistry of New Jersey, have also been involved with organizational issues that relate to the availability, quality and use of health services.

1191. NEUHOFF, C. F. **Outreach clinic experiment extends care with paramedics.** *Hospitals*, Chicago, 1977, Jan. 1, vol. 51, no. 1, pp. 77-80.

St. Francis Hospital, Peoria, Illinois, has established a framework of outreach

clinics to serve the urban poor in those areas geographically removed from the high-quality out-patient services provided by the hospital. The background to the establishment of out-reach clinics is outlined. At present there are three units staffed by paramedical staff and a physician supervises the units. The paramedical staff have received special training directed to the requirements of the work they are carrying out. In addition to the close support of the medical director, the laboratory and diagnostic facilities of the hospital are available to the units. The system takes care of a high percentage of immediate health care problems and also screens and selects those patients needing more complete medical attention. The financial support required for each clinic is discussed. The clinics avoid treating other doctors' patients, and there is support for the clinics from other doctors practising in Peoria. Each clinic sees 25 to 30 patients per day who would otherwise have had little chance of receiving medical attention. The system is a relatively inexpensive method of providing direct patient care to areas which it is greatly needed.

CASUALTY AND ACCIDENT

1192. MARON, C. Un exemple original de collaboration entre l'hôpital et les pompiers en matière de secours d'urgence. **[A unique example of collaboration between the hospital and the fire brigade in emergencies: the S.A.M.U. of Aurillac.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1977, April, vol. 32, no. 379, pp. 84-89.

The emergency medical services at Aurillac hospital are in radio contact with two fire stations (these provide the ambulances), the police, aerodrome, three other hospitals, and the civil defence helicopter. When an accident occurs in Aurillac itself the fire brigade informs the emergency service at the hospital of the location of the accident and the seriousness of the case. The doctor then takes his equipment to the scene in his car and from there accompanies the patient in the ambulance. If the scene of the accident is some distance away the fire brigade ambulance picks up the doctor at the hospital on its way or arranges a rendezvous by radio. This co-operative effort reduces the time taken for medical aid to reach the injured. The hospital to which the injured person(s) will be admitted is alerted in advance by radio. The article includes details of a record card which helps the doctor to assess the patient's condition from what he is told over the radio link.

1193. MOULET, M. A. Quelques problèmes juridiques posés par le fonctionnement des transports médicalisés. **[Some judicial problems concerning the transport of patients.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1977, April, vol. 32, no. 379, pp. 41-48.

Recent legislation in France has entrusted the emergency medical services to the public hospital. A hospital in a given sector provides a 24-hour answering service and an ambulance service, and assumes responsibility for the injured. The doctor in charge of the emergency services co-ordinates the various mobile units and either attends the scene of an accident himself or gives advice by telephone. The author examines the legal aspects of the hospital's and doctor's responsibilities at all stages of the operation, ranging from a simple malfunctioning of the answering service to misdiagnosis and incorrect treatment, with examples from cases recently dealt with in the courts. He suggests that the various tasks entrusted to the service, the division of responsibility

between the various organizations which attend the scene of an accident (ambulance, police, fire brigade), the functions of the doctor in charge, and the separate roles of the State and the public hospital within this context should be more clearly defined by statute.

CHEST

1194. GUNNELS, J. J. and BATES, J. H. **Shifting tuberculosis care to the general hospital.** *Hospitals*, Chicago, 1977, March 16, vol. 51, no. 6, pp. 133-134, 136, 138.

The provision of primary care services to tuberculosis patients has moved from specialized hospitals to general hospitals in the United States. Factors contributing to the change include: improved chemo-therapy; better understanding of the epidemiology; and greater concern for economics. Despite the advances in treatment many hospitals are reluctant to assume the responsibility for providing tuberculous patients with primary care. To assure the provision of high quality care only selected hospitals with appropriate out-patient facilities should assume the responsibility. The environmental factors required to prevent the spread of droplet nuclei are outlined together with the role of the laboratory. Since patients vary in their potential infectiousness each disease should be individually assessed. Each hospital should have an infection control committee responsible for implementing policies and for ensuring that patients receive high-quality care. The need to educate staff, provide consultation services and make sure that patients are properly referred at discharge are important functions of the committee. Only those hospitals willing to meet these minimum standards should assume this responsibility.

INFECTIOUS DISEASES AND ISOLATION

See Abstract No. 1194

CHILDREN

See also Abstract Nos. 1075, 1150, 1186

1195. KLINZING, D. R. and KLINZING, D. G. **The hospitalized child: communication techniques for health personnel.** Englewood Cliffs, N.J., Prentice Hall, 1977, vii, 168pp. £4.75

This book offers guidance to those who care for children in hospital, to meet the child's emotional needs through appropriate communication behaviour and strategies. Aspects covered include: methods of communication; the development of the child's communication ability; communication between hospital staff and children; communicating with parents and children; play and hospital schools; hospital methods and medical procedures; the dying child and his parents; and preparing and communicating with children in out-patient clinics and doctor's rooms. Bibliographies are included after each section.

1196. BURR, S. **Play for children in hospital.** *Nursing Times*, London, 1977, March 10, vol. 73, no. 10, ABPN supplement, pp. 5-6.

Expertise in play is limited even when all nursing staff with a responsibility for

children have received specialized training in the needs of the sick child. Nurses seeking information on play in hospital should turn to the voluntary associations which have pioneered play for children in hospital. These include the National Association for the Welfare of Children in Hospital, the Pre-School Playgroups Association, and the Save the Children Fund (Playgroups Department). Local education authorities and primary schools may also be prepared to help. The author provides a useful reading list; the report of the Expert Group on Play in Hospital and the Health Circular HC(76)5 are essential reading on this subject.

1197. HUNTER, M. H. S. **Paediatric hospital and home care. 1. Integrated programmes.** *Nursing Times*, London, 1977, March 10, vol. 73, no. 10, occasional papers, pp. 33-36.

Five integrated programmes of home care for sick children in Paddington, Birmingham, Edinburgh, Southampton, and Gateshead are briefly outlined. In three of them the staff are based on a children's hospital. Two schemes are an extension of hospital service for children who would otherwise remain in hospital or continue to attend out-patient departments. In these schemes the children remain under the care of the consultant. In Paddington, Birmingham, and Gateshead about 30 per cent of the children are referred by general practitioners and the remainder by hospital consultants, district nursing sisters, or health visitors. In every case direct channels of communication are maintained between the home nursing team and the hospital.

1198. HALL, D. J. **Problems of innovation in a hospital setting: the example of playleaders.** *Sociology of Work and Occupations*, Beverly Hill, Calif., 1977, Feb., vol. 4, no. 1, pp. 63-86.

This paper examines the effect of the introduction of playleaders into the children's wards of two hospitals in England and Wales. The types of playleader provision existing in hospitals are: (i) deployment of junior nurses by the hospital management committee; (ii) employment of teachers by local authorites; and (iii) the use of play-leaders through voluntary organizations or directly employed by the hospitals. This enquiry found that although the playleaders spent most of their time with the children, their work affected other staff in the wards and their relationship with them. Relations with the nursing staff were strained as the nurses sometimes considered that the playleader encroached upon their duties; on the other hand, they agreed that the playleader eased their job by relieving them of the time formerly spent playing with the children. Difficulties also arose with the domestic staff, owing to the untidiness created by play. Problems were also encountered in defining the roles of the teacher and the playleader, except in the English hospital where there was no such contact. Relations with the doctors were fairly remote but consultants were active in supporting the playleader experiment. The response of the staff to the playleader was therefore largely one of separation and the role of the playleader must be more clearly defined before their presence can be of substantial benefit to the children.

GERIATRICS AND LONG-STAY

See also Abstract No. 1218

1199. **Medical care of the elderly: report of the Working Party of the Royal College of Physicians of London.** *Lancet*, London, 1977, May 21, vol. i, pp. 1092-1095.

The Working Party was formed to consider how to solve the problems of the uneven

and inadequate medical care of the elderly and the difficulties of recruitment of doctors to that service. The background and development of geriatric medicine is discussed, and the need for improvement in accommodation and recruitment of junior and senior staff. The various services for the elderly-acute hospital care, progressive care, community care and psychiatric care are outlined. Recommendations of the Working Party include: (i) all acute medical and geriatric facilities should evolve into one integrated operational unit; (ii) physicians with training in general medicine and with a special interest and training in geriatric medicine should be appointed; (iii) all physicians with an interest in geriatric medicine should be actively concerned with care of the elderly outside the hospital; (iv) training in geriatric care should be an integral part of the experience of all those working or intending to work with the elderly; (v) family doctors should be more involved with the care of their patients; (vi) the need for places in part III accommodation should be kept under review; and (vii) special provisions are needed in both accommodation and care for old people with mental disorders.

1200. PEREZ, M. I costi sociali e sanitari dell'emarginazione degli anziani. **[The social and health costs of marginal care of the elderly.]** *Problemi della Sicurezza Sociale*, Roma, 1976, July/Aug., vol. 31, no. 4, pp. 311-340.

The proportion of elderly people in the Italian population continues to rise. This sector of the population now occupies 40 per cent of the beds in general hospitals and they stay there longer than before. At least 20 per cent of the elderly are admitted for social and family reasons. Although the number of hospital beds in relation to total population is lower in Italy than in other EEC countries, it is not practicable, nor is it wise, to go on building more hospitals. Alternatives such as day hospitals, decentralized out-patient services, and domiciliary services should be provided, and fuller use made of existing hospital equipment. Social and health services should be integrated at local level. Above all if the elderly were better integrated into the community, if, for example, they could go on working after reaching retirement age, they might feel better and make fewer demands on the hospital service. The article includes ten tables relating to expenditure on health and hospitals, hospital admissions, numbers of hospital beds, etc., in Italy and the other member countries of the EEC, and 40 references to publications on the problems of the elderly.

1201. MACDONALD, M. I. **Practical concerns for nursing the elderly in an institutional setting.** *Canadian Nurse*, Ottawa, 1977, April, vol. 73, no. 4, pp. 25-30.

To improve the general sense of well being of the elderly there are many steps that nurses can take on general and geriatric wards, or in the community. These steps can briefly be subdivided into physical and psychosocial care goals. The former are concerned with: (i) maintaining and improving muscle co-ordination and ambulation through an adequate supply of wheelchairs and feeding chairs, exercising and walking; (ii) looking after the personal appearance of the elderly; (iii) helping them to remain alert and aware whilst taking into consideration impairment of sight, hearing, taste, smell and tactile sensations; (iv) improving diets; (v) avoiding incontinence whilst increasing fluid intake; (vi) preventing constipation by fibre and fluid intake; (vii) helping to provide adequate rest; and (viii) preventing respiratory distress through deep breathing and humidification. The psychosocial goals are concerned with: (i) mastering

the environment and overcoming depression and anger; and (ii) encouraging better family and community relationships by adjusting the elderly to a new lifestyle, interpersonal communication and remotivation therapy. If these goals are met the elderly should feel a sense of mastery of their environment, become more aware of their surroundings and enjoy more productive relationships.

1202. KANE, R. L., HAMMER, D. and BYRNES, N. **Getting care to nursing-home patients: a problem and a proposal.** *Medical Care*, Philadelphia, 1977, Feb., vol. 15, no. 2, pp. 174-180.

In 60 of the 69 nursing homes in Salt Lake County, Utah, staff completed a short abstract of each of 2,071 patients' records; they were instructed to include information about all physician care. To examine the general patterns of care outside the nursing homes, the number of trips to health care resources were derived from the records of the three companies who provided transport services. The data suggest that the comprehensive care patients are under the care of various private physicians, but the majority of intermediate and personal care patients must rely on the house physician selected by the nursing home administrator. The university hospital out-patient department was the principal physician for 16 per cent of the comprehensive and intermediate patients. The transport records showed that in six one-week periods, a total of 1,133 trips were recorded. The majority (55 per cent) went to the university hospital; 27 per cent went to health care resources other than hospitals. A means of providing cost-effective primary medical care in the nursing home using a team of house practitioner and social worker is proposed.

1203. SMITH, W. G. **Complexities in assessing mental health care.** *Hospitals*, Chicago, 1977, Jan. 16, vol. 51, no. 2, pp. 109-113.

The apparent increase in interest in programme evaluation and quality assurance of mental health services has been mainly focused upon utilization review and cost control schemes, not upon evaluation and quality assurance. Evaluation of quality is defined, together with the various types of application. Studies conducted at the H. Douglas Singer Zone Center, Rockford, Ill., provide some examples of evaluation research and operational programme evaluation. One programme studied whether a community-oriented approach to mental health care was superior to the traditional state hospital system in achieving positive results. As a result the centre now promotes crisis intervention schemes for acute patients who need intensive short-term hospital care and studies to identify potentially chronic patients as early as possible are also being conducted. The operational programme evaluation scheme used ordinary patient flow information to examine the centre's aims. Several indexes were developed as part of each Unit's quarterly review allowing comparison of performances over a period of time. Guidelines are suggested for the development of an operational programme evaluation system. If these guidelines are followed evaluation can become a useful process in assuring quality of care. However, if unrealistic schemes are undertaken resources are likely to be wasted and programme improvement will not take place.

1204. BROCKLEHURST, J. C. **Brain failure in old age—social implications.** *Age & Ageing*, London, 1977, no. 6, supplement, pp. 30-34.

The author examines the question of stress caused in relatives by domiciliary care

of confused old people and that of residential care for the elderly, and in particular whether or not there should be separate homes for confused old people. He bases his examination on two books. The first, J. H. Sheldon's 'The Social Medicine of Old Age' (1947) described a survey of a random sample of pensioners in Wolverhampton, and Sheldon recommended an increase in short-term or holiday hospital admissions of mentally impaired old people so as to relieve strain on relatives. The second book, Meacher's 'Taken for a Ride' (1972), was based on a survey of six homes, three specially for confused old people and three in which these were integrated with normal people. Meacher concluded that the existence of separate homes for the confused tended to pre-judge mental confusion and led to the overuse of drugs. Of four models of feasible approaches to dementia which Meacher described (euthanasia, warehousing, horticulture, and social deprivation) the horticulture model (partial integration encouraging independence and self-sufficiency) is the one the author believes we are most likely to adopt.

NEUROLOGY AND NEUROSURGERY

See Abstract No. 1066

RHEUMATISM

1205. ARTHRITIS AND RHEUMATISM COUNCIL. EPIDEMIOLOGY RESEARCH UNIT. **Why the long wait?** London, Arthritis and Rheumatism Council, 1977, 19pp. £0.25

This report surveys the treatment facilities available for sufferers from arthritis and rheumatism. The quality and quantity of medical help for sufferers at all levels from the family doctor to the consultant is considered, together with the use of specialist services, in-patient resources and rheumatology manpower. The delays experienced by sufferers from rheumatic diseases in getting treatment and the gaps in treatment facilities available are discussed region by region.

VENEREAL DISEASE

1206. SATIN, A. **A record system for contact tracing.** *British Journal of Venereal Diseases*, London, 1977, April, vol. 53, no. 2, pp. 84-87.

A system for recording information on patients and contacts was developed during a research project by the Health Education Council in co-operation with the London boroughs of Lambeth and Wandsworth and the Sexually Transmitted Diseases Clinic at St. Thomas' Hospital, London. The record system has proved valuable in contact tracing, cross-referencing patients and their contacts, defining the characteristics of the patient and contact populations and providing information for research and management. The value of a standardized system has been accepted by health workers since it increased efficiency and improved the care of infected people. The use of the system for research is discussed. Since October 1976, health workers in 16 clinics, seven in London and nine outside, have used this system.

1207. LUNDIN, R. S., WRIGHT, M. W. and SCATLIFF, J. N. **Behavioural and social characteristics of the patient with repeated venereal disease and his effect on statistics on venereal diseases.** *British Journal of Venereal Diseases*, London, 1977, April, vol. 53, no. 2, pp. 140-144.

The increase in reported cases of venereal disease during the last decade has prompted

studies on the epidemiological, socio-economic and psychological factors associated with the spread of venereal disease. A study of 82 patients from St. Boniface General Hospital, Winnipeg, investigated personality characteristics and social circumstances. An effort was made to identify characteristics that would differentiate a repeat patient from a non-repeat patient. The results indicated that repeat patients differed significantly from non-repeat patients with respect to both environmental factors and personality characteristics. A second study was carried out to substantiate this hypothesis using medical records only from the Provincial Department of Venereal Disease Control. The results of both studies indicate that it is probable repeat patients make up a sizeable proportion of the total number of venereal disease patients in the population at large. The findings also suggest that the repeater may require a different prophylactic treatment from the non-repeater.

SURGERY

See Abstract Nos. 1129, 1150, 1158, 1166, 1168

MATERNITY

See also Abstract Nos. 1116, 1154

1208. LACHÈZE-PASQUET, P. Aspects économiques de l'hospitalisation en maternité. **[Economic aspects of maternity units.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1977, April, vol. 32, no. 379, pp. 77-79.

The average French mother spends eight to ten days in hospital after the birth of her baby. It would be more economic to discharge her after five or six days either to a convalescent home or to her own home where she would be looked after by a home-help and a visiting midwife.

1209. SLUTSKY, A. S. **Mathematical model used in forecasting maternity facilities needs.** *Hospital Administration in Canada*, Don Mills, Ont., 1977, March, vol. 19, no. 3, pp. 54-55, 58, 60.

The method used to forecast the obstetric resources required over the next decade at Henderson General Hospital in Hamilton, Ontario is described. Data concerning the use of hospitals in Hamilton were used to define the obstetric service area and estimate the catchment population. Estimates of future age-specific fertility rates relating to six age-groups and figures for the female population in each age-group, the number of deaths in each and empirical age-specific data on population movement, were used to estimate the number of births in Hamilton. The proportion of these births which would take place at Henderson General was calculated, using a model developed on the hypothesis that the number of patients using a hospital varies inversely as the square of the distance patients have to travel to the hospital. Finally, to determine the number of obstetric beds required to meet expected demand, the average daily census for each year was estimated, and various allocation strategies and their consequences in terms of obstetric beds, labour beds, and delivery rooms were then elaborated.

1210. Ottó, G., Iván, I. and János, K. Perinatális intenzív centrumok kialakítása és felszerelése. **[Organization and equipment of perinatal intensive centres.]** *Egészségügyi gazdasági Szemle*, Budapest, 1977, March, vol. 15, no. 1, pp. 79-92.

The organizational and technical problems connected with the establishment of perinatal intensive care centres within the framework of obstetric or paediatric departments or university hospitals are discussed. The most frequent disease requiring a child's admission to hospital is the idiopathic respiratory distress syndrome, the treatment of which has considerably improved over the past years. The construction and engineering installations of the units, which frequently contain 14 beds or incubators, are discussed. The units are suitable for the accommodation of premature and new-born babies requiring artificial respiration or intensive care. The equipment required is discussed. Each unit should have an area of 20m^2 per incubator and a staff of 46. Seven such units are at present in use in Hungary, and three further centres are being developed. The importance of reliable communication networks and a well organized ambulance service is emphasized.

PSYCHIATRY

See also Abstract Nos. 1108, 1111-1114, 1134, 1179, 1186, 1203-1204

1211. Weimer, W. and Thomas, M. **Toward a hospital policy on drug abuse patients.** *Hospitals*, Chicago, 1977, Jan. 1, vol. 51, no. 1, pp. 81-82, 92.

The Drug Abuse Advisory Committee of the Ohio Hospital Association Research and Educational Foundation developed recommendations for establishing a policy on the treatment and referral of drug and alcohol abuse patients. The recommendations suggest that a hospital should conduct an objective study of the problems in the area as it affects both the hospital and the community. The hospital should then review and redefine its response. The policy should contain provisions for: (i) the hospital's responsibility for the treatment of drug and alcohol abuse patients; (ii) a patient's right to confidentiality; (iii) notification requirements of police; (iv) referral and transfer of patients; and (v) special consideration e.g. local laws. After a patient's medical status is stable, an evaluation should be carried out regarding aftercare, and possible referrals to other facilities should be discussed. The institution should be asked to inform the hospital whether or not the patient was seen. This requirement should be specified in the hospital policy statement.

1212. Cochrane, R. **Mental illness in immigrants to England and Wales: an analysis of mental hospital admissions, 1971.** *Social Psychiatry*, Berlin, 1977, vol. 12, no. 1, pp. 25-35.

A study of all admissions to psychiatric hospitals in England and Wales in 1971 was carried out by place of birth. The results revealed that not only do the various immigrant groups included in the study differ from the native born group but they also differ from each other. Migrants from within the British Isles to England have higher rates of mental illness than the native born. Immigrants from overseas have varied rates, many of which are lower than those of the native born. Rates of admission for schizophrenics are higher for the foreign born than the native born, but some of this excess may be accounted for by the age structure of the population. The Irish and Scots had high

rates of alcohol and drug related disorders and personality and behaviour disorders, but West Indians were under represented in these diagnostic categories. Various explanations are considered. It is concluded that the most tenable hypothesis is one of differential self-selection for migration depending upon economic conditions in the country of origin and relative difficulty of migration.

1213. FRIED, A. L. and FRIED, F. E. **Hospital and community psychiatric nursing.** *Journal of Psychiatric Nursing & Mental Health Services*, Thorofare, N.J., 1976, Dec., vol. 14, no. 12, pp. 31-36.

Psychiatric nurses in community mental health centres and in general hospitals take part in: (i) psychotherapy; (ii) supervision of drug administration; (iii) emergency treatment; and (iv) after-care of patients discharged from psychiatric hospitals and units. Preventive nursing is a vital part of community psychiatric care and the nurse can teach mental health care to independent groups and in co-operation with hospitals and welfare departments. She also plays a part in the early detection and treatment of disease through: (i) home treatment; (ii) suicide prevention services; (iii) out-patient treatment; and (iv) consultation services. Within the hospital, the psychiatric nurse helps the patient to socialize and take part in occupational, recreational and social activities, thus helping to produce a therapeutic community. She reports on the patient's progress and gives advice at patient/staff meetings. In a psychiatric hospital an experienced psychiatric nurse assumes total nursing responsibility for the patient, in co-operation with the psychiatrist.

1214. KRZEMIEN, J. N. **Impact of unit system reorganization in two state psychiatric hospitals.** *Journal of Psychiatric Nursing*, Thorofare, N.J., 1976, Oct., pp. 19-27.

The unit system involves a subdivision of a large psychiatric hospital into smaller units or sections, each with its own administrative authority and assignment of staff providing a full range of mental health services. The main aims of the system are: (i) to increase staff participation in decisions affecting patient care; and (ii) to increase the unit staff's influence over the budget and staff selection. A total of ten units in the Trenton and Marlboro Hospitals, New Jersey, were investigated to assess the effectiveness of the unit system in achieving these aims. With the exception of one unit at Trenton, all units showed an increase in staff participation in budget and staffing decisions, especially in the latter. A high percentage of staff from both hospitals reported that communication between unit staff had increased since decentralization. Professional nurses made up the largest category of staff who reported increased participation, indicating that the unit system allows the staff who have most contact with the patients to participate in decisions affecting their care. Detailed results of the survey are shown in four tables.

1215. OXFORD UNIVERSITY. DEPARTMENT OF PSYCHIATRY. **A survey of the need for secure psychiatric facilities in the Oxford Region.** Oxford, Oxford RHA, 1976, [iv], 106pp.

The findings are presented of a survey made in 1975 to determine how many people from the Oxford Region might require psychiatric treatment under conditions of security intermediate between the openness of most National Health Service psychiatric

hospitals and the maximum security of the Special Hospitals. Aspects considered include: historical background; characteristics of the proposed regional security units and their patients; and the size of the problem. The methods and results obtained from the survey are presented. A list of references is given (pp. 105-106).

1216. BURR, J. and BUDGE, U. V. **Nursing the psychiatric patients. 3rd edition.** London, Baillière Tindall, 1976, viii, 296pp. £2.50

This third edition of a handbook on the care of psychiatric patients covers the syllabus of the pupil nurse in psychiatric training. Early chapters outline the psychological development of the individual and explain what may cause people to become mentally ill. Later chapters deal with practical details of ward routines—meal times, exercise, leisure, treatment, sleep. Emphasis has been given to the need for developing the nurses' skill in helping institutionalized patients, and aspects considered include physical treatments, and drugs. The growing need for better provision by local authorities for discharged patients is stressed, including the need to give support to the relatives of the patients.

1217. MUNGOVAN, R. **Home from hospital.** *Nursing Times*, London, 1977, April 28, vol. 73, no. 17, pp. 620-621.

Fulbourn Hospital, Cambridge, has devised a system by which psychiatric patients leaving hospital to live in group homes have a greater chance of success. It is based on a committee called the housing council, which includes representatives of the hospital, Cambridge Mental Welfare Association, local authority housing and social services departments and voluntary bodies. The development of the housing council is outlined and its aims and functions are listed. In the three years of its existence, it is clear that this committee has enabled patients in the group homes to be resettled into local communities more successfully than before. Important points needing to be taken into account when attempting to place people in group homes are: (i) assessment and selection; (ii) preparation; (iii) liaison with the Department of Health and Social Security; (iv) liaison with general practitioners and community-based social workers; (v) preparation; and (vi) adequate follow-up and support care.

1218. GOLDSTONE, L. A. **Long-stay female population in a psychiatric hospital.** Part 1. *Nursing Mirror*, Sutton, 1977, March 17, vol. 144, no. 11, pp. 67-68.

A study of female in-patients of a large psychiatric hospital who had been continuously hospitalized for two years or more revealed that of the patients aged 65 and over, 46.3 per cent suffer either a single handicap or a combination; the incidence of the handicap rapidly increased with age. The degree of nursing care thought appropriate for each patient was analysed. Overall 46.8 per cent of long-stay females needed minimal nursing care; 25.3 per cent needed supervision in feeding, toileting, dressing and drugs; and 28 per cent needed full physical nursing care. The results indicated that the number of elderly in the old population is being reinforced by new arrivals and that the problems involved in nursing aged, handicapped, incontinent psycho-geriatric patients will grow in the coming years. The problem is likely to become exaggerated as the pattern of present admissions and discharges perpetuates the system. There is a possibility that psychiatric nursing care is taking second place to the immediate physical nursing, given the magnitude and expected growth of the latter.

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